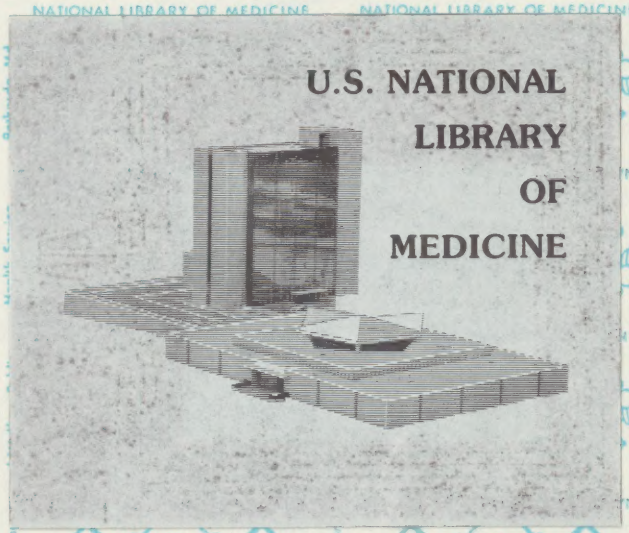

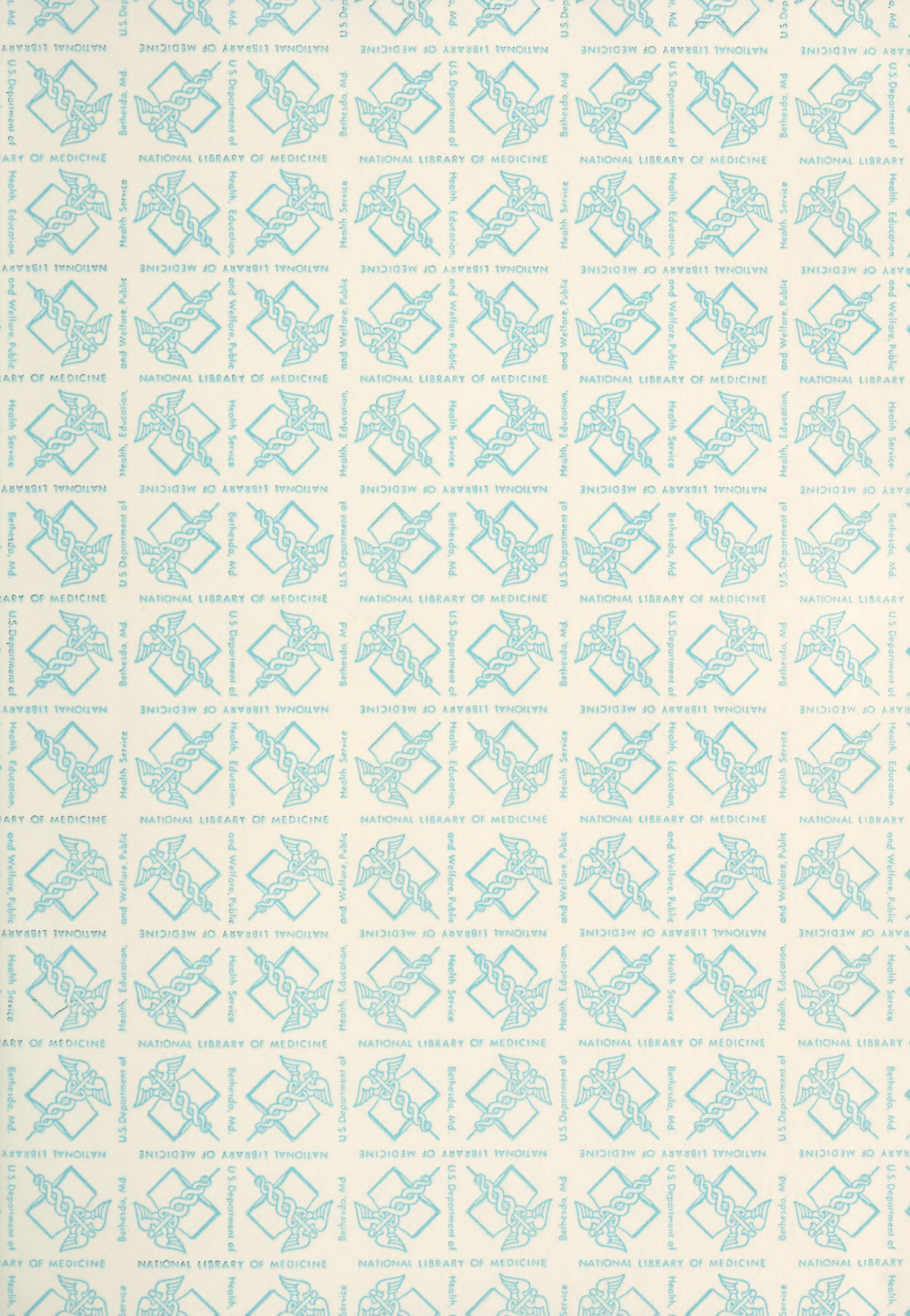
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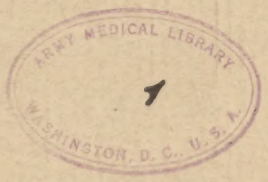
Report

to the

Commission on Organization of the Executive Branch of the Government

by the

Committee on Federal Medical Services



NOVEMBER 1, 1948

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Not printed at Government expense

COMMISSION ON ORGANIZATION
OF THE
EXECUTIVE BRANCH OF THE GOVERNMENT

1626 K Street, N. W.
Washington 25, D. C.

November 30, 1948

Honorable Herbert Hoover, Chairman
Commission on Organization of the
Executive Branch of the Government
1626 K Street, N.W.
Washington 25, D. C.

Dear Mr. Chairman:

Herewith is the unanimous report of your Committee on Federal Medical Services, dated November 1st. Preceding the report itself is a brief summary of the weaknesses found and the remedies proposed.

Appendix A to the report, setting forth the Committee's organization for its task, is bound herewith. The other appendices are bound separately.

Since Admiral Boone was appointed and has served solely as Secretary to the Committee, not as a member of it, he has not participated in the substance of the report or in its conclusions and recommendations.

Sincerely yours,

Frank R. Bradley, M.D.
Robin C. Buerki, M.D.
Michael E. DeBakey, M.D.
Goldthwaite H. Dorr
Paul R. Hawley, M.D.
Henry P. Isham
Hugh R. Leavell, M.D.
William C. Menninger, M.D.
Hugh J. Morgan, M.D.
O. H. P. Pepper, M.D.
Alfred N. Richards, Ph.D.
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Ray Lyman Wilbur, M.D.
Edward D. Churchill, M.D.
Vice Chairman

Tracy S. Voorhees
Chairman

J. T. Boone
Rear Admiral (M.C.), U. S. Navy
Secretary

TABLE OF CONTENTS

APPENDICES[1]

[1] Appendix A bound with Report; all others bound separately.

Summary of Report of the Committee on Federal Medical Services

Our Method of Work: Following the Commission's example, we delegated specific fields to task forces. For certain of these we secured experts who were added to the committee. Other fields were within the particular experience of original members of the committee. Still others were covered by securing eminent advisors to the committee.

Our objective has been, not to test the efficiency of particular agencies, but rather the adequacy of the governmental medical organization as measured against the Commission's objectives. For the faults we have found, we blame principally the competitive organizational climate in which the various agencies have striven to maintain themselves, rather than the agencies themselves. You instructed us to approach our task courageously without undue solicitude for traditional organizations. We have tried to do so. Our study is, in a real sense, only a beginning, but we believe it to be a beginning which needed to be made.

Assumptions We Have Made: (1) That it must be a basic principle that whatever medical care the Government provides must be of the highest quality which can be sustained by the best possible organization of the strictly limited human resources available. (2) That the Commission will recommend a Cabinet Department embracing health, education and security.

Magnitude of the Medical Problem: Four big and some forty smaller agencies of the Government spent about one and one quarter billion dollars for health and medical services in fiscal year 1948, an increase of five times over 1940, and of 20 percent even over 1947. In 1949, the V. A. alone will spend as much as all forty-six agencies did in 1948—half of it for new hospitals.

The United States gives varying degrees of care to 24,000,000 beneficiaries—about one-sixth of the nation. Eighteen and one-half million of these are veterans. There are now over 100,000 V. A. hospital beds in operation, and a further increase by one-third is now in process. One estimate prepared on the basis of hospitalization of veterans of the first World War projects 300,000 V. A. beds as probably necessary under present policies by 1980. Even if only service-connected cases and chronic nonservice-connected cases—the latter being almost all medically indigent—should be given care, an

actuarial study made for us indicates need for 250,000 beds by 1975, and that of these three-fourths would be for mental cases. In these estimates it has been assumed that no further war will occur.

Weaknesses in Existing Organization

This enormous and expanding enterprise is *devoid of any central plan.* Four large, and various smaller agencies, obtain funds and build hospitals, each to care for its own clientele. They compete with each other for scarce personnel. Generally, no one of them considers the facilities available in, or the needs of, the others. No one has responsibility for any over-all plan. There is not even any clear definition of certain classes of beneficiaries for whom care is to be planned. The Government is moving into uncalculated obligations without an understanding of their ultimate cost, the lack of professional manpower available to discharge them, or the adverse effect upon the hospital system of the country. *Fundamental to all others is the conclusion that there must be over-all planning and that this in turn requires first a clear definition of the extent of the responsibilities and second an organization appropriate to carry out the commitment.*

We tested in several ways whether the existing setup squares with the Commission's objectives:

1. **Spotlight by areas**: We inspected five representative areas and obtained necessary data on others. As examples:

In the New York City area we felt that under unified management four Army and Air Force hospitals—none of which is professionally adequate—could be closed, reducing requirements for medical officers by 80 percent (from 60 to 10), but at the same time providing a higher standard of care. We found that the absence of integration of Federal hospitals produced a waste of physical plant, and underutilization of scarce military medical personnel; further, that ambitious plans of all but one of the agencies to build new hospitals are likely to make the situation worse. Costs of their planned construction are over $100,000,000. This will double the permanent plant, with no prospect of staffing it, and no satisfying evidence that additional beds in such amount are needed.

In the San Francisco area, there are 13 Federal hospitals with a total constructed capacity of 9,900 beds and only 4,200 patients at the time of survey. Proper integration would permit the closing of 7 of the 13 hospitals. Their closing would reduce bed capacity by about 20 percent and still leave the remaining 6 hospitals—even after trans-

ferring to them the patients from the 7 closed hospitals—with only 54 percent of constructed capacity occupied.

In Houston, we found V. A. building a $25,000,000 NP hospital, immediately adjacent to the Navy hospital, because the Navy decided to retain as an NP center a hospital built during the war. This was built under an arrangement that it would revert to V. A., and for the past two years only about 10 percent of its constructed capacity has been required for Navy personnel. Under unified planning, Navy would not need this installation, and the entire cost of the new V. A. hospital could be saved.

In Honolulu, the Army has just completed a hospital costing $37,000,000, started during the war, although the Navy has nearby a permanent modern hospital plant adequate for all military personnel of all three services in that area of the Pacific. Under unified planning, the cost of the Army hospital, except to the extent of construction completed before Japan surrendered, could have been saved. Its operation is unnecessary.

2. **Spotlight by Certain Diseases**: We selected TB and NP which together fill 60 percent of V. A. beds and are the greatest expense to the Government. Our task forces, working separately, found as to each of these diseases that the present organization is unsatisfactory; that it developed piecemeal, with little comprehensive planning; that it involves duplication and inefficiency; that there is an acute shortage of medical personnel, aggravated by the unsound organization; that there is imperative need for unification.

3. **Spotlight on Construction**: The current V. A. building program alone will cost $1,100,000,000. The armed forces desire another $200,000,000 for construction. Large V. A. hospitals cost about $20,000 a bed; small ones over $30,000. One is costing $51,000 for a single bed. They are being built at vastly greater cost than the per bed cost of community non-Federal hospitals. They contain facilities not needed for patients who really require hospital bed care. The construction plans often do not fit the need of the V. A.'s Medical Department which must operate them. Nearly half of the 89 new V. A. hospitals are being built or planned in areas where experience has proven that it will be difficult, if not impossible, to secure adequate staffs. Further, construction of these may prevent erection of essential hospitals near medical centers which can be staffed and can give the best care.

V. A.'s program conflicts with the Government's policy under the Hill-Burton Act of aiding non-Federal hospitals for the purpose of establishing a sound hospital system for the country as a whole. It

competes with such hospitals for scarce personnel. It diverts patients from them and threatens the community interest that the Hill-Burton Act was designed to stimulate.

4. **Spotlight on Patient Stays:** Compared with representative voluntary hospitals, patients with the same diagnoses stay in Government hospitals two to three times as long. In the same Army and Navy hospitals civilians stay only half as long as military personnel. Making all discounts, stays could be greatly shortened under a unified system with proper planning, aided by the fact that the patients would be nearer home.

5. **Spotlight on Medical Manpower:** We have studied this first in the armed forces separately. A very large part of the medical officers were educated at Government expense during the war and are now rendering obligatory service. Most of them leave within the next six months. Voluntary recruitment has failed, and increase of the armed forces under Selective Service is aggravating the deficiency. A draft is necessary, but it will bring in only young doctors who cannot provide high-grade specialist care. Except in war, if adequate medical care is to be given, specialists must be utilized in their home communities.

In the non-military Federal agencies, none has the manpower resources in sight to meet its full responsibilities. The condition is neither temporary nor self-correcting. In the V. A. alone, 5,600 beds are now closed because of inability to staff them. The best opinion available is that not over 120,000 V. A. beds can be staffed. Construction is far outrunning manpower.

Present organization and practices make for inefficiency in utilization of professional personnel.

6. **Spotlight on Definition of Federal Beneficiaries:** An enormous plant is being built for groups of beneficiaries to whom the Federal obligation is not clearly defined.

Some 900,000 dependents of Army and Air Force personnel are being given complete care virtually free on no basis other than an appropriation act over sixty years old authorizing medical officers to care for dependents "whenever practicable." Acquiescence in this practice by appropriation has occurred year after year.

As to veterans with nonservice-connected disabilities, there is authorization to hospitalize them only if a bed is "available." Yet 100,000 V. A. hospital beds have been built or authorized which serve no purpose except deliberately to make beds available for nonservice-connected cases. Congress must have expected that care to this extent

would be given or it would not have appropriated funds for the beds. The fiction of limiting the right to care only if a bed is available thus leads to construction of a Federal plant of staggering cost, when much of the hospitalization might be more efficiently provided in community hospitals on a reimbursable basis.

Remedies

The present numerous agencies concerned with similar medical activities must be integrated into two major systems—military and non-military. For the non-military system, we recommend a new National Bureau of Health, part of the proposed Cabinet department. It should be headed by a professional, career Director General, and manned by career personnel drawn initially from existing agencies. It should include at least three main divisions: (1) Medical Care, (2) Public Health, (3) Research and Training.

In the continental United States there should be transferred to the Medical Care Division: (1) all general hospitals of the armed forces (with the exceptions indicated below), and station hospitals, except those at outlying posts so located that hospitals of the National Bureau of Health would not be near enough to provide the hospitalization they would require; (2) the medical functions of the Veterans Administration *in toto,* including the outpatient services in the regional offices of the V. A.; (3) the hospitals of the Public Health Service; (4) St. Elizabeth's Hospital. Each of the three armed forces should retain one medical research and teaching hospital, which would include a general hospital, the station hospitals above excepted, and all hospitals overseas. Other hospital functions which should not be transferred include hospitals of the Bureau of Indian Affairs, the hospitals of the Bureau of Prisons, and other small hospital functions such as those which are incident to T. V. A. and the Atomic Energy Commission. The Indian and prison hospitals should be fully staffed by professional personnel from the National Bureau of Health.

This radical departure from traditional functions is proposed, not merely to save money, but because it is the only means by which high quality care can be maintained with the present shortage of doctors in Federal service. Furthermore, it would provide better medical protection in time of war.

Basically underlying these proposals are: (1) As to armed forces' general hospitals: A large number of the patients are of little further military value. These general hospitals cannot maintain quality staffs because they lack specialists. High quality care could be given in a unified system, as many V. A. (and some P. H. S.) hospitals which

would be transferred to such a system are well staffed with specialists because of their association with teaching medical centers. We have found no other way to give high quality care to the armed forces. (2) As to the transfer of V. A. hospitalization to the new Bureau: This follows automatically under the Commission's instructions to place like functions, where possible, together. The fact too that the V. A. hospitals are the largest single group with over half of the total Federal beds, would mean that, if they were to remain separate, the new Bureau of Health would be a central health agency in name only. Further, only by incorporating the V. A. hospitals can an integration be achieved which will provide high-grade specialist care for the armed forces, and only by this means can scarce medical manpower be efficiently utilized. Also, a very large reduction in hospital beds can be achieved by the above plan. Our area surveys, which covered about one-sixth of the country's Federal hospital beds, showed that new construction costing over $100,000,000 could probably be saved in these areas alone by such a plan.

The staffing of such a hospital system should be generally along the lines of the law (P. L. 293, 78th Congress) under which the professional quality of V. A. medicine has made such great strides.

Integration with Non-Federal Hospital System: The present inconsistency in policy between the V. A. construction program and Federal aid to non-Federal hospitals under the Hill-Burton Act should be ended. Inadequacies exist in the nation's hospital plant. The Federal government has recognized the need for aid in remedying them, and is now giving such assistance. This effort would be furthered by placing Federal cases in non-Federal hospitals on a reimbursable basis wherever it is efficient to do so, instead of further enlarging the Federal hospital plant. In that way, many veterans could be cared for near home in their community hospitals. If beds are inadequate for Federal patients, extension of assistance in construction on a grant-in-aid basis, under which the Federal government pays only part of the cost and the community bears the rest and assumes responsibility, should be the method of choice. This step is further indicated because the Federal government is dependent upon voluntary and other community teaching hospitals for undergraduate and post-graduate training of medical personnel, and for the advancement of medical science by joint efforts with the medical schools affiliated with them. Many of these hospitals are in financial trouble. They are vital resources of the nation. They, together with other community hospitals, should be utilized and not weakened by unrestricted V. A. hospital competition.

Beneficiaries: Clear definitions by Congress as to beneficiaries entitled to medical care from the Government, and as to how it may be given, are essential for sound planning. The question of the Government's decision to assume the financial burden for medical care should be separated from the entirely different question of giving the care in Federal hospitals.

As to dependents of armed forces personnel: The same policy must apply to all three services. The right to such care has been held out as an inducement, and is a morale factor. The question is really one of pay of the armed forces, except overseas and in posts in this country remote from adequate community facilities and professional personnel where the right to such care is an essential part of military medicine. As part of the compensation of armed forces personnel, the Government either should arrange directly to pay, under proper controls, for care of dependents in community facilities in acute—not chronic—cases, or should provide a health insurance premium in a non-profit insurance plan for dependents.

As to veterans with nonservice-connected conditions, the present situation is inequitable to the veteran and unsound and expensive for the Government. Whatever care is given should be accorded in the facilities, whether Federal or community, in which it can be furnished most efficiently and with optimum utilization of scarce professional personnel.

We do not consider it to be the function of a committee largely composed of professional medical members, and presumably selected for technical qualifications, to determine the basic question of philosophy of government as to how much the Government owes to its veterans. But a basic clear decision must be made by Congress between giving care to all veterans more or less irrespective of financial need, or to those with nonservice-connected conditions only if they are in real need. In any case, there is no necessity for financial screening of chronic cases, as substantially all of these are soon made medically indigent by their disease. They would be a charge on the public in any event. As to the acute (temporary) cases, if Congress adopts the second of the above alternatives, a possible method would be to offer a health insurance plan which would include professional care. As to veterans unable to pay the premium for this, payment would, on determination to this effect, be made by the Government. Under such plan, veterans who neither take out the insurance themselves nor arrange, because of financial inability, for the Government to do it for them, would not be entitled to care for nonservice-connected conditions, except of course emergencies which no hospital would

refuse. Such insurance might be supplied by extension of existing non-profit plans, or, if this should not prove practical, this purely voluntary insurance could—if necessary—be written by the Government itself for this class of its wards.

As to armed forces medicine after such change: Unification of medical services supporting the armed forces would be most efficient. But it must be geared to the extent of unification of the services themselves. Medicine cannot be merged alone. But duplication can be avoided by assigning responsibility in each overseas area to one service to give hospital care for all. Further, there should be supervision by a deputy—preferably an Assistant Secretary—of the Secretary of Defense, with broad power, aided by an advisory committee including civilian doctors.

Draft of Doctors: The above proposals will greatly reduce armed forces medical requirements, but not sufficiently to avert a draft. The draft should be limited for the present to A. S. T. P. and V-12 graduates who have rendered no service—of which there is a pool of about 8,500—and thereafter to others who have been deferred to pursue their medical education.

Medical Protection Should War Occur: The above hospitalization plan is a sound and necessary measure for national defense. The overwhelming shortage of doctors which war would create would thereby be met by optimum utilization of those we have. Not only would the proposed single Federal hospital system reduce the need for doctors and enable them to care for Federal beneficiaries without leaving their communities, but it would also assist in saving doctors because it could be fully integrated with non-Federal hospitals. In an atomic age, physicians cannot be taken from their communities as they were in the last war. To do so would destroy essential civil defense.

Public Health and Research Functions: These would be centered respectively in two divisions of the National Bureau of Health, which would take over existing functions of these kinds.

Aid to Medical Schools: Many schools are in serious condition. Government aid will probably be necessary, and is urgent. Yet adequate facts on which to base the extent of, or to beam intelligently, the aid required are not now available. There should be a short range survey immediately made by the P. H. S. to determine the real needs for emergency aid, amplified later by a longer range study. Any aid must

be given in a manner to maintain the professional independence and the initiative of the schools, and in a way which will increase the output and result, partially at least, in meeting especially acute present deficiencies.

Medical Supply: A unified supply system for medical items—those used to treat patients—would effect a great saving. It could cut the present total of Federal medical depots to about one-third of those now operating. If the armed forces will make medical supply a responsibility of one of the three services, so that it could be assured of single and effective management, the service so selected should conduct supply for all the armed forces, the National Bureau of Health and other incidental government needs. Otherwise, during peace the National Bureau of Health should supply the armed forces, with armed force personnel detailed to its supply system. A unified medical supply, including standardization of items and assemblies and a single system of depots, is also necessary as a medical protection should war occur.

Over-all Supervision: There is needed a strong, but small top-level organization to carry forward on a permanent basis the studies begun by our committee. It should be aided by a medical advisory committee, and should go beyond the purely negative control of trying to hold down budgets. It is requisite because the necessity for a separate medical service for the armed forces prevents a complete unification of Federal medicine, making continuing supervision necessary to prevent duplication between military and civilian medicine. More than an occasional glance at possible duplication in the armed forces themselves might also pay dividends.

We express unanimously our anxiety concerning the dangers in uninhibited expansion of Federal medical expense and our conviction that strong measures are necessary to control it. If all present objectives cannot be provided for within the Government's capacity to pay, our report offers suggestions for priorities.

An Affirmative Approach: Just as the medical profession developed a defensive attitude through preoccupation with treatment of the sick, so Federal medicine has, to a large extent, developed negatively with patient care as its principal function. *Transcending in importance any of our other recommendations, is the need to outflank disease by giving the highest priority to research, preventive medicine, public health and education.*

First is the need for maximum employment of present scientific knowledge to control disease. But beyond application of present knowledge lies research to find new weapons. Research and public health together since the turn of the century have made it possible to postpone by about 20 years the death of the average new-born child. Medical research has conquered plagues and numbers of mortal diseases. It is today a resourceful, potent force of incalculable humanitarian, national and world value. It is also imperative to maintain constantly a high level of medical research activity as a protection to us in war. Such research must be stimulated, and supported to the extent which may prove necessary, to the maximum potential of the skilled manpower available to conduct it.

Since the Federal government now has wards totalling one-sixth of the nation to which it gives varying degrees of care, and since it faces an enormous growth in veterans hospitalization as World War II veterans grow older, the Treasury can be protected best by using every means to prevent disease rather than by unlimited hospitalization to treat it. This will also promote both the national welfare in peace and a stronger manpower to preserve our security in war. The highest priority in Federal medical expenditures should, therefore, go to the research, preventive medicine and public health fields. We must not just treat patients. We must, and to a large degree we can, if we will, control disease.

Report

Acting on your mandate from the Congress, you appointed us to study the organization and functioning of all Federal medical services —those in the armed forces being at first excepted but later added— and to recommend those changes we thought necessary to promote economy, efficiency and improved service. You instructed us to approach this task courageously without undue regard for traditional functions or existing organization.

Pursuant to your chairman's instructions, and in accordance with the statute creating the Commission (Public Law 162, 80th Congress), our recommendations are directed not only toward limiting expenses and eliminating duplication and overlapping, but also toward consolidating like functions and, where necessary, abolishing services and functions as well as defining and limiting them.

According to your chairman's instructions, we have proceeded upon the assumption that the Commission will recommend a new cabinet-level department embracing health, education, and security, in which the broad field of health will be one of the three major functions; also that standard Government nomenclature below the department level will be "bureau" and thereafter "division." We, therefore, describe the health organization which we propose as the National Bureau of Health in such new department.

The above instructions excluded from our consideration the question as to whether a separate Cabinet department would be established for health alone, as urged by professional groups. However, should this be done, the organization which we are proposing would be adapted to such plan with only a few changes in nomenclature.

We have proceeded upon the basic principle that whatever medical care the Federal government provides must be of the highest quality which can be sustained by the best possible organization of the strictly limited human resources available.

During the war, a high standard of medical care was given to our armed forces by putting into uniform a large segment of the country's leading specialists of military age. The spectacular results of this care in reduction of mortality and in restoration of sick and wounded to health are too well known to need elaboration. Only such a standard can be the guiding principle for any sound Federal organization.

We are convinced that a basic reorganization is essential; that without it such a high level of medical care is impossible to maintain; that without it, we will have a disorganized, inefficient and extravagant series of unrelated projects; but that with it, it will be possible not only to create a Federal medical service which will give better care to the Government's direct beneficiaries but provide the needed help to voluntary and state agencies to push on toward the goal of a stronger and healthier nation.

Because of the profound impact of Federal hospitalization upon the medical care of the nation as a whole, we found it essential to explore the relationship of Federal medical and health activities to those of state and local governments, community hospitals and medical schools. The crucial shortages in medical manpower cannot be comprehended or dealt with if these are not considered. In doing this, we are thoroughly aware of the boundaries beyond which Federal action would jeopardize local government and stultify the initiative of private activity. We have sought to avoid any course by which the Federal government would overstep such proper bounds.

We believe that compulsory national health insurance is not a question of Federal medical service as you employed these words in describing our task; but rather that it is a question of broad philosophy and policy of government. As such, we feel that it is outside our terms of reference.

You have instructed us to indicate the priority of recommended activities. We have attempted to do this. In it we emphasize the importance of giving a very high priority to research, preventive medicine and public health activities. The most expensive and most damaging policy is to focus attention and funds principally on hospitalization, while at the same time neglecting research, preventive medicine, public health and education. We have sought to avoid such a negative approach. Instead, we have recommended a long-range frontal attack upon diseases which impair the health and productivity of the nation. We believe that in the long run emphasis on preventive measures will not only reduce immeasurably the cost of Federal medical services, but also strengthen the security of the nation and improve the welfare of our people.

We fully realize the challenge and the magnitude of our task. To carry it out, we followed the Commission's example of dividing our work among task forces, each of which includes the committee members, or in some cases other experts, best qualified to deal with the particular subject assigned. They, with our advisors and our full-time staff, have devoted months of painstaking effort to these studies. Our method of organization and list of personnel are set forth in Appendix A (bound herewith).

We assembled, digested and studied reports previously made dealing with this general subject. From many of them we have learned much. We informally consulted with Federal agencies and professional organizations, and invited their representatives and those of various veterans' groups to appear before our committee. The information and opinions so received have been extremely helpful.

The reports of our task forces, most of which were subcommittees, constitute the background for this report. They give a fund of basic information and a body of informed opinion which furnish a foundation for the solution of the problems referred to us. The most important task force reports are submitted as appendices, but are bound separately. Additional detailed material of potential future usefulness will later be assembled for the Commission's records.

We pointed our work toward determining a basically sound organization for Federal medical services, the reasons for it and its relationship to non-Federal services, and erecting certain signposts as to how the new organization might proceed. So conceived, our assignment became possible. But implicit in this limited definition of our function is the necessity for inclusion in the organization which we propose of a permanent unit to continue such studies as our committee has begun and as our work has proved necessary. Our studies can then be used as a basis for more detailed analyses not possible in a survey limited to a period of months. Recommendations for this are included herein as a matter of the highest importance.

I. THE MAGNITUDE AND ORGANIZATION OF FEDERAL MEDICAL ACTIVITIES

The Government is now responsible for medical care in varying degrees for almost 24,000,000 people, or about one-sixth of the entire population. By 1947 it was expending well over a billion dollars, five times the 1940 cost. By fiscal year 1948 this cost jumped another 20 percent to one and a quarter billion. For fiscal year 1949, the appropriation allocated to the Veterans Administration's medical

program alone (almost one-half of which is for construction of new hospitals) approximately equals the expenditures of all agencies in fiscal year 1948. The total Federal medical budget for fiscal year 1949 is estimated at $1,923,000,000.

One estimate, which we believe to be too conservative, fixes 175,000 to 200,000 as the number of V. A. beds required in twenty to twenty-five years. Another estimate (made by the American Hospital Association) indicates that, assuming continuation of present policies and rates of hospitalization, requirements for hospital care for veterans alone will probably triple in about twenty years, requiring 300,000 beds.

Even if only service-connected cases and chronic nonservice-connected cases—the latter being almost all medically indigent—should be given care, a study (made for us in the Metropolitan Life Insurance Company) indicates need for 250,000 beds by 1975, and that of these three-fourths would be for mental cases.[1] In all of the above, we are assuming that no further war will occur.

The present Federal hospital building program for the next three years includes $1,100,000,000 in hospitals for the V. A. alone, several of the smaller ones costing over $30,000—and one over $51,000—for a single bed.

Projects for Federal hospital construction desired by other agencies bring the total current expenditures proposed or under consideration roughly to $1,300,000,000 for about the next three years, exclusive of $75,000,000 annually to aid non-Federal hospital construction.

This Great Enterprise is Devoid of Any Central Plan

The most striking impression made upon us in our study is that this enormous Federal medical project has been entered into and is now being conducted without any central plan, without even any clear decision as to certain of the large classes of the beneficiaries to be covered, with no estimate of the ultimate cost or of the effect upon other health measures for the nation.

Four great agencies in the medical field, and various smaller ones, obtain funds each year, erect their own hospitals to care for their own clientele, and compete with each other for scarce personnel, with no regard for the facilities available in, or the needs of, the other agencies, and without any over-all plan. As matters now stand, the Government is moving into uncalculated obligations without consideration or understanding of their ultimate cost. It is proceeding with no

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[1] See Actuarial Projections in Appendix L.

adequate thought as to whether it can staff its hospitals to give good care, and without any unified plan as to how to do the job.

One conclusion fundamental to all others is inescapable: There must be over-all planning. This in turn requires a clear definition of the extent of the responsibilities, and an organization appropriate to carry out the commitment.

General Outline of Activities

Appendix B of this report (bound separately) details present Federal medical activities. The following is a general outline:

They run along two principal lines: (1) activities promoting the general health of the public as a whole, and (2) direct medical care of Federal beneficiaries. The second of these constitutes 85 percent of total expenditures. Such care is given primarily in Federal installations, and in varying degree to the following principal groups: (a) veterans; (b) armed forces personnel and their dependents; (c) Coast Guard and other quasi-military personnel and their dependents; (d) merchant seamen; (e) Federal prisoners; (f) Indians; and (g) civilian Federal employees.

The independent, uncoordinated direction and execution of the principal activities is distributed among at least seven major departments and agencies. There is no over-all central direction or planning of these diverse activities except as the Bureau of the Budget may act as a brake on expenditures.

The chief Federal agency for public health activities and research is the Public Health Service. But the Food and Drug Administration, the Department of Agriculture, the Children's Bureau and other agencies separately carry on certain of such functions in the interests of the public at large, and the armed forces conduct extensive programs for military personnel.

The direct medical care of patients is largely a function of the Veterans Administration, the Army, the Navy, the Air Force (which has no separate medical department but is seeking to establish one which will be independent except that it will exclude general hospital care); the Federal Security Agency through the hospitals of the Public Health Service, St. Elizabeth's Hospital and Freedmen's Hospital; the Bureau of Indian Affairs of the Interior Department, and the Department of Justice. Limited medical services are also rendered by other Government departments, e.g., to civilian employees under industrial hygiene type programs.

Generally, each agency has its own medical personnel and installations. However, the Army furnishes personnel for the Air Force, and the Departments of Interior and Justice in varying degree

make use of medical personnel detailed from the Public Health Service.

The following table gives an idea of hospital beds and their utilization in the major agencies:

Agency	Beds (6/30/48)		Patients (6/30/48)	
	Capacity	Operating	Number	Percent of Total Beds
TOTAL	255,601	200,336	155,882	61.0
Department of National Defense	105,061	58,128	32,683	31.1
Army and Air Force	70,419	33,626	18,725	26.6
Navy	34,642[c]	24,502	13,958	40.3
Federal Security Agency	16,641	17,738	14,027	84.3
Public Health Service	9,143	10,240	7,300	79.8
Other[a]	7,498	7,498	6,727	89.1
Department of Interior	4,074[d]	3,872	2,407	59.1
Department of Justice	2,754	2,205	1,216	44.2
Veterans Administration[b]	127,071	118,393	105,549	83.1
All Other Agencies	[d]	[d]	[d]	

[a] Includes St. Elizabeth's and Freedmen's Hospitals.
[b] Includes both hospitals and domiciliary homes; in latter there were 14,259 patients.
[c] Dispensaries included at operating capacity.
[d] Excludes a very small number of beds and patients in dispensaries of the Coast Guard and the Maritime Commission.

While of course there are important functions other than hospital care, the numbers of hospital beds and patients are convenient yardsticks with which to measure the direct hospital program of each agency.

The following table represents the obligations for all health and medical services of the major agencies in the fiscal year 1948:

Agency	Obligations	Percent of Total
TOTAL	$1,246,315,746	100.0
Veterans Administration	759,748,289	61.0
Department of National Defense	249,794,373	20.1
Army and Air Force	161,409,391	13.0
Navy	88,384,982	7.1
Federal Security Agency	184,263,060	14.8
Public Health Service	126,691,597	10.2
Other	57,571,463	4.6
Department of Agriculture	16,528,243	1.3
Atomic Energy Commission	15,119,455	1.2
Department of Interior	9,676,833	0.8
Department of Justice	1,607,296	0.1
All Other Agencies	9,578,197	0.7

Of the aggregate annual expense in 1948 of $1,246,315,746, the V. A. spent about 61 percent, F. S. A. 15 percent, Army and Air Force 13 percent, and Navy 7 percent.

Of the gross total of 1.25 billion, about 70 percent was spent for inpatient hospital care (including construction) and another 14 percent for outpatient care. These ratios vary for the different agencies.

Only 3.9 percent of the total was spent for all aspects of research, and 8.9 percent for preventive medicine and public health, which present the only means of holding within reasonable dollar bounds the future costs of hospitalization and other curative treatment. Most of the agencies charged with providing medical care for their own beneficiaries are so preoccupied with this immediate demand that research and prevention are of secondary importance.

It is estimated that aggregate expenditures of the country as a whole for health and medical care currently amount to about nine billion dollars, of which the Federal portion (in 1948) was approximately 14 percent.

There are an estimated 1,425,000 hospital beds in the various hospital systems of the country as a whole, grouped as follows:

Hospital System		Number of Beds
TOTAL		1,425,000
Voluntary		395,000
Government		1,030,000
State and Local	830,000	
Federal (operating)	200,000	

Thus about one-seventh of all the hospital beds in the country are under the control of some Federal agency. In addition, the V. A. is planning or has already contracted for the construction of 55,000 additional beds, of which 10,650 are under construction, presumably as replacements for beds in obsolete or temporary hospitals. The armed forces plan an additional 5,000 and the other agencies substantially fewer.

In summary, then, a substantial fraction of the medical service in the country is now under direct Federal control; the V. A. is by far the largest of the Federal medical care services; and further increases in the magnitude of the Federal medical effort are to be expected.

Beneficiaries of Direct Care

Federal beneficiaries are the basis on which the structure of governmental medicine rests, for all but 15 percent of the 1948 expendi-

tures was for the direct care of patients. At one extreme are members of the armed forces and their dependents, merchant seamen, and other lesser groups totaling upwards of 3,000,000 persons, all entitled in substance to complete medical care. At the other extreme are 2,000,000 employees of the Federal government whose coverage is limited to industrial accidents and outpatient care of the industrial-hygiene type. Veterans, estimated to number 18,500,000, constitute the bulk of the population of beneficiaries. Although today the great majority of the veterans are entitled to care on the basis of service in World Wars I and II, one must not overlook the future eligibility of present and future personnel of the military establishment, now being maintained at greatly increased strength. For this reason the veteran population is a growing one.

II. WEAKNESSES IN THE PRESENT ORGANIZATION OF FEDERAL MEDICAL SERVICES

Congress clearly stated the objectives of the Commission as the consolidation of similar functions, elimination of duplication, and promotion of economy and efficiency. It is plain from the foregoing outline of the present activities why there is no provision for joint planning and integration of effort, for Federal health functions have been clustered in a haphazard fashion about independent groups of beneficiaries. Such lack of plan necessarily results in unrelated systems of hospitalization and medical care. But what is the price for this lack of integration? After much though we decided to approach this question from a number of very different points of view, and chose the following means to spotlight the adequacy of the present organization:

A. Survey of Federal hospitalization by area

B. Study of the management of the two disease groups which require the largest Federal expenditures—tuberculosis and neuropsychiatric illness

C. Examination of the Federal hospital construction program

D. Comparison of lengths of stay in Federal and non-Federal hospitals

E. Analysis of supply and demand in medical manpower, first for the armed forces and then for the Federal medical services as a whole

F. Scrutiny of the definition of those entitled to medical care

Detailed documentation, beyond the intent of the present summary, will be found in the various appendices to this report.

A. Spotlight on Federal Hospitalization by Area[1]

Surveys in New Orleans, New York City, San Francisco, Los Angeles, and San Diego, and investigations of special situations in several other areas, show that the present organization is impotent in the effective utilization of Federal hospitals and medical manpower.

1. **New Orleans**—There are five Federal hospitals, all within a radius of five or six miles from the center of the city, with a total capacity of about 1,600 beds. At the time of our survey their situation was as follows:

Agency and Hospital	Beds		Patients
	Capacity	In Operation	
TOTAL	1,620	1,278	913
V. A. General Hospital	670	579	477
P. H. S. General Hospital	500	572	365
Navy Station Dispensary	150	27	28
Navy Air Station Dispensary	100	25	2
Army Station Hospital	200	75	41

The two general hospitals were completely staffed with about 100 full-time qualified physicians representing all the specialties and backed by able local consultants. They are closely associated with the local medical schools, and are actively engaged in residency training and research. They are able to give medical care of excellent quality. On the other hand, the smaller Army and Navy hospitals are not satisfactorily staffed in point of quality to give the best medical care even of the station-hospital type. Further, patients needing prolonged or highly specialized treatment must be sent to Army and Navy general hospitals in San Antonio, Houston, Pensacola, and other locations many miles away.

Lack of over-all planning for Federal hospitalization here results in a waste of physical facilities and of scarce manpower, and in a relatively poorer quality of care for military personnel. The patient-load regularly carried by these Army and Navy hospitals is so small that it could apparently be absorbed by the P.H.S. hospital, where much better care could be given, and from which men would seldom have to be sent to more distant hospitals. Instead, the P.H.S. hospital now provides about 175 beds for veterans (which on net balance serves merely to add

[1] Report of Subcommittee on Hospitalization—Area Surveys, Appendix C.

this number to the total of nonservice-connected cases provided for by V.A.) and 10 beds for Navy obstetrical patients. It is certainly not an obligation of a Public Health Service Marine Hospital to give such care to veterans. In effect, at present, armed forces personnel are being given a lower standard of treatment simply because, under the present system, there is no pooling of resources.

Closing of the three small armed forces hospitals, which now cost several hundred thousand dollars annually to operate, would leave as the only requirement the provision of dispensary (outpatient) facilities on the military posts themselves. Such dispensary care would require only a few of the twelve doctors now staffing the three hospitals. Thus, at a time when both the Army and Navy are short of medical manpower and plan for a draft of doctors, well over half of the armed forces medical personnel in this area might be saved by unified hospital planning and better care could be given military personnel.

2. **New York City:** There are 11 major Federal hospitals in New York City within a radius of 20 miles with good transportation connections. These hospitals have a total capacity of 8,257 beds, an operating capacity of 6,949 beds, and when surveyed held 5,330 patients, or 77 percent of operating capacity and only 65 percent of total capacity. About 7,000 people were employed in these hospitals, including 630 full-time physicians. At the time of our survey the situation was as follows:

Agency and Hospital	Beds		Patients
	Capacity	In Operation	
TOTAL	8,257	6,949	5,330
Veterans Administration			
Bronx	1,670	1,542	1,397
Halloran[a]	1,500	1,125	1,005
Manhattan Beach[b]	400	350	304
Public Health Service			
Neponsit Beach[c]	250	300	257
Staten Island	869	1,050	745
Ellis Island	435	454	300
Army and Air Force			
Fort Totten General	121	100	48
Fort Jay Station	350	284	164
Fort Hamilton Station	300	100	36
Mitchell Field Station	250	143	87
Navy			
St. Albans	2,112	1,500	987

[a] Owned by New York State, but return not yet planned.
[b] To be returned to Public Health Service.
[c] To be returned to New York City.

One of the V.A. hospitals is affiliated with a medical school, and all of the V.A. hospitals have well-qualified specialists and consultants on their staffs and provide medical care of excellent quality. The P.H.S. hospitals have qualified specialists and a good training program, making use of consultants from the New York City medical schools. The Navy hospital is from eight to eighteen miles from the surrounding Army and Air Force installations, is well-staffed, has active consultants from the medical schools, and is able to provide medical care of high quality. The four Army and Air Force hospitals, which include one small general hospital, are not able to give a quality of medical care commensurate with that available in the other Federal hospitals.

In the V.A. hospitals, 83 percent of the 1,774 general medical and surgical patients were being treated for nonservice-connected disabilities. In the Navy hospital approximately one-third of the patients were veterans and dependents. In the Army hospitals 28 percent of the patients were dependents. The Fort Totten Army hospital acts as an Army center for obstetrics in the area, with half of its patient-load consisting of dependents. The hospital at Fort Hamilton was the Army center for children, 35 of its 36 patients being children at the time of survey.

As an illustration of what might be possible, it appeared to us that the V.A. hospitals could absorb the V.A. patients now in the Navy hospital, raising their utilization of constructed capacity from 76 to only 82 percent; that the 335 patients (including 94 dependents) in the Army and Air Force hospitals could then be cared for in the Navy hospital, where in this area their care would be of better quality, changing the utilization from its present 66 percent of operating capacity to about 75 percent. (This could be done even without change in the policy of caring for dependents.) Four Army and Air Force hospitals could then be closed; only dispensary (outpatient) care would then be required at the posts concerned. Such steps would save many hundreds of thousands of dollars in annual operating costs, reduce the Army and Air Force medical officers by 80-85 percent and at the same time provide better medical care for service personnel.

As in New Orleans, we found in New York City that the absence of integration of the Federal hospitals produced a waste of physical plant and an extravagant utilization of medical personnel by the armed forces. Moreover, priority in the limited amount of high quality care available in Federal hospitals is being given to veterans with nonservice-connected disabilities (entitled to care only if a bed is available) at the sacrifice of armed forces personnel to whom the Government owes an unqualified obligation.

We also believe that there is grave danger that the present situation will worsen if not corrected by vigorous measures. All but one of the major Federal agencies with hospitals there have ambitious plans to construct new hospitals. In so doing, they are acting independently of each other and of the program of the state and city, and with insufficient consideration of the availability of professional personnel.

It seems probable that these construction programs will lead, at great expense, merely to a large unused capacity. Of the 8,257 Federal bed capacity in the New York City area, 3,133 are temporary, most of these being the 2,100 beds at St. Albans. This leaves about 5,124 beds in permanent construction compared with a patient load for all agencies of 5,330 patients. including dependents and veterans with non-service-connected disabilities. These comprise almost half the total number of patients. In addition to putting up a new 1,000 bed hospital in Newark, and another of 1,965 beds in nearby Peekskill, the V.A. is already building a new 981-bed hospital in Brooklyn, and the Army, Navy, and V.A. together are planning four additional hospitals with a capacity of 4,500 beds. Thus under this program the present permanent plant of 5,124 beds would soon be more than doubled, with a projected capacity of 10,335 beds, which would be approximately twice the present patient-load. With all possible allowances, including the return of Halloran to the State of New York and the planned increase in the size of the military establishment, it is difficult to see the wisdom of so huge a construction program. Apart from the hospitals in Newark and Peekskill (excluded from the analysis), this will cost $105.2 million. We are convinced that these plans could be radically reduced by central planning, based on the area as a whole.

Apart from cost, there is the problem of staffing. Difficulties are already being encountered in obtaining physicians for Federal hospitals. Yet in the New York area alone, a hospital construction program has been formulated which would double present requirements for physicians.

A highlight is provided by a recent announcement of a new permanent Navy cancer hospital being constructed at the St. Albans site. The construction contract for $14,800,000 includes a betatron for cancer radiation that is said to be "the largest ever built for cancer therapy". We question why the care of cancer patients, except minor superficial cases, should be a responsibility of the armed forces at all. Patients with cancer requiring deep radiation therapy can rarely be of further military value.

Another highlight is provided by the fact that the New York Hospital-Cornell Medical Center (one of the two or three finest hospital

plants in the world with an outstanding medical staff) has 150 beds closed because of nursing shortage. Here there is no medical staffing problem, no construction required, and the highest type of care for the most difficult cases could be provided on a reimbursable basis. Instead, the new Federal hospital construction tends further to strip the existing hospitals of nurses by outbidding them. Integration of Federal planning with the non-Federal hospital system is presently wholly lacking, although under the Hill-Burton Act assistance to local hospitals is a Federal policy.

3. **San Francisco**: The same lack of coordination among Federal hospitals exists as was found elsewhere, with in general the same evils. Exclusive of specialized (TB and NP) V.A. hospitals, there are 13 Federal hospitals in this area, representing all the major Federal medical services. They have a total capacity of 9,905 beds and a patient load of 4,180. The analysis showed that a more efficient utilization of these facilities by proper coordination of their activities would probably permit the closing of 7 of these 13 hospitals, representing almost a fifth of the total bed capacity and providing a uniformily high quality of medical care. Even with all the patients now in these 13 hospitals cared for in the remaining 6 hospitals, the total occupancy rate would be only 54 percent of their constructed capacity.

Moreover, the Army and Navy requirements for physician personnel in this area could be reduced by about 10 or 12 percent, even with a generous allowance for dispensary (outpatient) needs. This does not include considerable savings which might accrue from a change of policy in the care of contingent beneficiaries, i.e. dependents and veterans, who constitute approximately 40 percent of the patient load in the Army and Navy hospitals in this area. If medical care for these dependents and veterans were provided by other means, as later proposed, armed forces requirements for physicians in this area could be reduced by another one-third of the present total.

The local need for hospitals around San Francisco is considerable. At present the Federal government under the Hill-Burton Act is financially aiding construction of new hospitals, while at the same time holding beautiful, modern hospitals in the area of which it is not making effective use. For example, the new Navy hospital at Moffett Field is largely unused (average daily census, two patients during fiscal year 1948) but there is need for hospital beds in the surrounding local area. Further, plans are being worked on looking toward the construction in this area of three more permanent Federal hospitals to

provide a total of over 3,000 additional beds at a cost of perhaps $70,000,000, despite the fact that the permanent Federal hospitals now there could accommodate the entire patient load with a total occupancy rate of only 68 percent.

4. **Los Angeles:** The survey showed that probably five Navy hospitals, representing about 30 percent of the total capacity in the 12 Federal hospitals there, could be closed under a unified hospital plan.

In this area the armed forces are using about half of their doctors in the care of patients other than personnel on active duty. If this care of "supernumeraries" were provided for by other means, the Army's hospital could be closed, in addition to the closing of Navy hospitals above mentioned, and all active duty military personnel in the area could be cared for in one Navy hospital. This would reduce the requirements for Army and Navy doctors in this area by almost one-half.

At Corona, the Navy is maintaining a center for chronic patients (tuberculosis and paraplegia), although almost none of such patients will ever return to active military duty and should be transferred to the V.A. This might well save the government the $21,000,000 cost of the proposed new V.A. hospital of 1,000 beds in this area.

5. **San Diego:** There are 10 Federal hospitals, all but two within a radius of 15 miles. The survey showed an even greater dispersion of medical resources with resultant inefficiency in their utilization. The total number of patients (1,611) in the area (veterans, dependents, and other supernumeraries included), amounts to just about the operating capacity of one of the Navy's general hospitals in this area. With the possible exception of the patients at two of the hospitals, all of the patients in the small hospitals could easily be accommodated at the one large general hospital, providing a uniformly better quality of care and a considerable saving in personnel utilization.

In addition to the above more comprehensive area surveys, we noted several other special situations:

For example, in **Houston,** Texas, a 1,000-bed Navy hospital was built at a cost of $12,000,000 during the war. It had been approved originally with the express understanding that it would revert to the V.A. as a post-war facility. Yet because the Navy has now decided to keep it, the V.A. is letting bids for a new 1,000-bed hospital at an estimated cost of $25,000,000 immediately adjacent to the Navy hospital. At the time of our study the Navy hospital had only 437 patients, of whom 304 were veterans, and only 124 were Navy personnel. There are no major Navy installations in this area. During the past two years active duty Navy patients have occupied only an average of about 10%

of the total capacity of this hospital. The Navy is now making this hospital a neuropsychiatric center. However, the Navy now has 26 general hospitals with a total constructed bed capacity of about 28,000 beds (only about 46 percent of which are occupied). They have only about 900 neuropsychiatric patients. Under a unified over-all Federal plan, transfer of this hospital would be possible, saving the entire cost of building and operating the proposed V.A. hospital.

In **Honolulu** the Army has just opened, three years after the war, the new 1,500-bed Tripler General Hospital. It was completed in spite of the fact that the adjacent Navy hospital, only seven years old and of permanent construction, could meet all current needs of armed forces patients in the area. The original plan was for an Army hospital costing $11 million, but finally over $37 million—$25,000 per bed—has been spent. Pursuit of this building plan after the close of the war is evidence of what lack of unified planning can cost, since the Army went ahead without counting upon availability to it of Navy beds.

In Summary:

In these area surveys there exists a similar pattern of duplication of physical facilities, waste of scarce medical personnel, inadequate quality of medical care for armed forces personnel at smaller installations and unwarranted construction of new facilities—all resulting primarily from the lack of a central plan for Federal medical care. More specifically:

Too many small military hospitals are kept open when efficiency in utilization of personnel requires concentration of patients in centers: Taken together the military hospitals, with a constructed capacity of 21,555 beds and a presently operating capacity of 12,851 beds, contain about 7,800 patients, giving occupancy rates of about 36 and 60 percent respectively.

Too large a part of the medical resources of the armed forces are devoted to the care of civilians, veterans and dependents of military personnel. Of the total 7,800 patients in these armed forces hospitals only 61 percent are active duty military personnel.

Military hospitals continue to care for an appreciable number of chronic patients who should be discharged to the V.A. more promptly.

Hospital construction is planned by the major Federal agencies for their own individual needs without coordination of medical needs and resources. In consequence, one agency will build a new hospital near an empty or nearly empty hospital of another.

At the present time, on the basis of existing policies, and even allowing for increase in the requirements of the various agencies, there

is in these areas alone excess capital expansion under contract or in some stage of planning of an estimated cost well over $100,000,000. This sum alone is more than twice that being expended at the present time annually by the Federal government for medical research.

There are repeated instances in which contingent beneficiaries are hospitalized in a large, well staffed general hospital while many active duty military patients in the same area are cared for in small, inadequately staffed hospitals. This phenomenon occurs even when such hospitals have ample room for both military and non-military patients.

Finally, it is plain from the results of these surveys that the Federal government lacks any means of coordinating the medical programs of the separate agencies. So competitive is the environment in which they operate that no one agency can now take a government-wide point of view. As long as this system continues, uneconomical use of medical manpower and facilities will continue.

B. Spotlight on Certain Diseases

Shifting to a different approach, we selected tuberculosis and neuropsychiatric illnesses for special study because, together, they fill some 60 percent of V.A. beds. Measured in Federal cost, they are among the greatest disease problems. We, therefore, sought to analyze the present Federal medical setup by appraising its adequacy as to them. Task forces on each were created. The following is a summary of their findings:

1. **In tuberculosis,**[1] our task force (headed by Dr. Robert E. Plunkett, with Dr. Esmond Long as consultant) found that, although reduced 78 percent since 1910, tuberculosis still causes 50,000 deaths annually in the United States. There is an estimated minimum of 500,000 cases. It is essentially not an individual, but a family and community disease. Hence, it has been accepted largely as a public responsibility. The measures essential to its control are discovery, segregation, treatment, and rehabilitation.

Because it is not only a medical treatment problem, but also a public health, social and economic problem which affects the entire community, the several essential techniques for its control cannot be separated. Time in hospital is often only a small portion of the total period of care. Thereafter, the tuberculosis hospital cannot be operated with full effectiveness unless integrated with all other community services for control. However, several Federal agencies entered this field separately with their own hospitals as a branch of general

[1] Report of Subcommittee on Tuberculosis, Appendix D.

hospital care for their beneficiaries, not primarily for control of the disease. There is little or no integration with programs of other Federal agencies or with the control programs of state and local agencies. Annual cost to the Federal government is about $60,000,000, or almost nine times the total grants-in-aids to states for control of the disease.

The V.A. is not soundly organized to deal with this disease because of subordination of medical direction to non-medical personnel and the absence of a clear-cut medical line of authority.

In the Indian hospitals, there is lack of integration with other Federal agencies and state and local facilities.

The successful control of tuberculosis requires adherence to two principles, namely, that clinical treatment, without regard to public health implications, retards control, and that treatment of the patient is best carried on in intimate relationship with the community of which he is a part and near his family. Both principles are violated by the present Federal system. In general Federal programs consist merely of clinical treatment. A patient is not cared for in even the Federal hospital nearest his home, but must go to the hospital of the agency charged with his care. This weakens family and community ties which sustain the patient in his illness, and through which all control measures except hospitalization must necessarily be effected. It is not the least of the influences which make it difficult to keep patients in hospital. The necessary continuity of care in and out of hospital is destroyed.

Further, the Federal agencies spend their money with little purposeful regard for the programs of the various states and communities for control of the disease. There has been an almost complete lack of coordination of hospital planning of the Federal agencies with those of states. The same applies to hospital use and operation.

Federal programs were developed piecemeal, with little comprehensive planning.

Since state hospital needs are calculated on the basis of estimated cases in the population, including the veterans, there is presently a duplication in hospital planning.

Operation of separate TB hospital programs by five Federal agencies results in duplication and inefficiency. There is imperative need for integration.

There is a shortage of physicians specially trained in tuberculosis, especially in the Federal service. This is aggravated by lack of coordination among the Federal agencies, causing competition for, and inefficient use of, this scarce personnel.

2. **In neuropsychiatric illnesses,**[1] the conclusion of our task force (headed by Dr. Menninger) is that no Federal program exists in these fields but only unrelated endeavors centered chiefly on the care of patients.

Its findings are that no single agency has more than partial responsibility for national leadership in this field, where over-all leadership is most urgently needed. The National Mental Health Act of 1946 is but a mere beginning in this direction.

In the main the Federal agencies engage in the treatment of psychiatric illness, and do not have preventive programs. Through grants-in-aid, the Public Health Service has recently begun to stimulate state mental hygiene programs. Outpatient care in the V.A. is strictly limited by law to service-connected conditions, although the consensus of psychiatrists is that an outpatient program could do much to prevent the development of serious, chronic disease and thus greatly reduce the need for expensive hospital care. Illustrative is the fact that nothing adequate is being done to prevent the occurrence of thousands of cases of paresis, although it is possible, and although each such paretic will cost the U. S. at least $40,000 for life-time care.

V.A. hospitals now provide a quality of care approaching that of the private neuropsychiatric hospitals, and far better than that of the state hospitals.

There is an acute national shortage of psychiatrists, which is even more severe in the Federal medical services. They have about 1,000 and need an additional 900. Ancillary personnel in this field are in equally short supply. Even in residencies, 27 percent are vacant in the V.A. alone. The ratio of neuropsychiatric patients to qualified psychiatrists and neurologists in the Federal system is about 70 to one, so that only inadequate active therapy can be attempted.

In general, in the Federal medical services the authority of professional medical personnel is limited and actually subordinate to that of non-medical personnel. This is most striking within the V.A. This divided responsibility results in a poor administrative organization, interfering with morale and efficiency in the V.A. hospitals. There is inadequate authority in the Chief Medical Director of the V.A.

Although the supply of personnel is inadequate, patients are hospitalized who in non-Federal systems of care would be handled as outpatients; and for equivalent cases the average length of stay in Federal hospitals greatly exceeds that in private hospitals.

Each of the major agencies has its own top administrative and planning staff for this disease.

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[1] Report of Subcommittee on Psychiatry and Neurology, Appendix E.

Except for the V.A., each agency has its neuropsychiatric patients in so many different installations that it is unable to effect the personnel economies which result from concentrating patients in centers. So uncorrelated are the programs that two Federal NP hospitals may exist in the same community. There is no exchange of personnel among the agencies. The cumulative effect of the independent operation of small, unrelated neuropsychiatric programs on a national scale is an inefficient utilization of a very scarce type of medical manpower.

In the face of the above extreme shortage of neuropsychiatric personnel in the Federal service, extensive plans are being made for hospital expansion. In addition to the 56,000 bed capacity available for neuropsychiatric patients in the V.A. on 30 June 1948, another 17,000 beds are being planned or are already under contract, an increase of 30 percent. These beds are needed in the national economy, but it is a grave question whether the Federal government should erect an independent hospital system of its own, devoid of community roots, for approximately one-seventh of the total U. S. population.

C. Spotlight on Construction Programs

Of total new beds in various stages of planning, about 85 percent consists of the V.A. program, so we limit comment to it. Last July the V.A. had under contract, or was proposing to contract for, an additional 54,000 beds in 89 new hospitals and additions to 11 others—a gross increase of 52 percent of its present operating plant of 102,219 beds. Depending upon how many of the 21,000 existing beds in 28 temporary structures (acquired from the armed forces after the war) are ultimately closed, the new construction will represent a net addition of at least one-third in V.A. beds. It will add two-thirds to the existing operating capacity in permanent construction.

The V.A. hospital building program alone amounts to $1.1 billion as presently projected, almost as much as all agencies together had spent in construction and maintenance of Federal hospitals prior to 1945. Of this amount about half had been appropriated by June 30, 1948. The plans of other agencies for construction—in various stages of consideration—may add another $200,000,000. Including the Hill-Burton Act funds, hospital construction now in contemplation by all agencies, covering a period of about three years, amounts to over $1.5 billion.

Voluntary hospitals are reported to be still able to build efficient hospitals for about $16,000 per bed. Compared with this, veterans hospitals cost from $20,000 to $51,000 per bed.

The average per bed costs of V.A. general hospitals for which contracts were let in 1948 for each of the principal size groups are:[1]

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1 The detailed tables on which these figures were based are annexed to Appendix B.

Number of Beds	Average Cost Per Bed
1000	$20,000
500	22,000
300	26,000
250	27,000
200	29,000
150	33,000
100	51,000

It will also be noted that the cost per bed increases in inverse ratio to the number of beds, so that smaller hospitals cost 50 percent to 100 percent more per bed than the big hospitals. The smaller hospitals are not only more expensive but more difficult to staff on a full or part-time basis because of their remote locations. Moreover, larger installations near medical schools and metropolitan centers can be staffed without displacing doctors from their communities, and can depend upon access to superior specialists. They have the additional advantage of proximity to sources of other important categories of supporting staff, especially nurses and attendants.

Significant facts to be noted in connection with the above figures are:

1. There is a great discrepancy between cost per bed in V.A. hospitals and in community non-profit hospitals.

2. One reason for huge costs in V.A. hospitals is the inclusion of recreational facilities, large dining rooms in general hospitals for a convalescent ambulatory class of patients, and offices for various organizations. Such facilities are as a general matter unknown in voluntary general hospitals and would serve no purpose in similar V.A. installations if patients were promptly discharged when their real need for hospital care ceases. V.A. hospitals also include an abnormally large amount of office space for other V.A. functions (such as finance, claims, records), and other purposes not strictly medical.

3. New hospital construction is going forward at great expense although the Chief Medical Director of the Department of Medicine and Surgery, who has responsibility for the care of the patients, does not desire such construction and does not believe he can staff the hospitals.

4. Small V.A. hospitals cost disproportionately more than those with large bed capacities, both to construct and to maintain.

5. The more costly smaller hospitals are to a very large extent the ones which the Chief Medical Director of the Department of Medicine and Surgery does not want, because of his anticipated inability to staff

them. They are located in areas where experience has convincingly proven difficulties in staffing. After they are built, it will be impossible to utilize fully the facilities so created and give a high standard of care. Such hospitals, therefore, mean both great cost to the Government and poorer care to the patients.

6. The large amounts of money spent on small inefficient hospitals may prevent much more essential construction of hospitals near medical centers which can give the best care to the veterans and which have proven over the past three years the key to the significant elevation in standards of veterans' care. Although the V.A. (which presently has 5,600 beds idle for lack of personnel) cannot, in the opinion of either its present Chief Medical Director or his predecessor, expect to staff more than 120,000 beds with qualified personnel in the foreseeable future, the present building program will increase its bed capacity and, therefore, its present shortages of staff, by a third or more.

The problem is aggravated by poor choice of location for many hospitals. There are 17 existing hospitals with 15,600 beds for which the Department of Medicine and Surgery has stated that it is unable to provide a satisfactory professional staff. Similarly, 12 hospitals now being planned, with a total of 3,000 beds, are so located that it is not expected that they can be staffed. Another 30 with 11,000 beds can be staffed only with difficulty. Part of the above condition is explained by the taking over, after the war, of temporary Army and Navy hospitals, six of which are poorly located for V.A. purposes. But the future program also includes badly located hospitals, products not of design but of pressures. To place these hospitals where they will have difficult staffing problems, and will lack the intimate day-to-day advice of expert part-time consultants from the nation's best teaching hospitals and medical schools means poor care instead of good care. It is a disservice to veterans and a waste of tax funds. Yet, ten of the twenty-eight general medical and surgical hospitals now under construction by the V.A. are in such areas.

Continuance of present policies may lead to a V.A. hospital system of 300,000 beds by 1980.

7. Finally, the V.A.'s vast construction program, which is clearly required only for the care of nonservice-connected cases, is thoroughly inconsistent with the other policy of the Government of aiding non-Federal hospitals under the Hill-Burton Act. It competes with them for scarce professional personnel other than physicians, pays higher wages for such personnel, drains off from such hospitals part of their patients, and weakens local support for construction of community

hospitals. We believe these destructive implications are not clearly understood.

D. Spotlight on Patient Stay in Hospital

Length of stay was studied as a striking index of hospital utilization. By averaging a large number of selected uncomplicated surgical procedures, we obtained a usable yardstick of the relative length of stay in Federal and in a representative number of voluntary general hospitals. We also compared the lengths of stay of active duty military personnel with those of civilians in military hospitals. These studies showed:

Operative Procedure	Average Length of Stay in Days[a]						
		Federal Hospitals					
	Voluntary General Hospitals	Public Health Service Marine	Veterans Administration	Army General		Navy General	
				Active Duty Personnel	Other [b]	Active Duty Personnel	Other [b]
Appendectomy	7.8	11.9	14.3	19.6	9.9	20.3	9.6
Tonsillectomy	1.4	6.8	15.1	16.1	3.0	13.3	2.5
Hemorrhoidectomy	6.9	11.8	34.3	27.3	15.2	25.7	10.2
Herniotomy (Inguinal)	10.3	16.0	27.0	29.4	16.1	28.1	13.4

[a] Patients discharged between January and August, 1948
[b] Excluding veterans

This table brings into clear focus the fact that patient stays are excessive in Federal hospitals, and particularly for active duty personnel in military hospitals, if consideration is given, as it should be, to real need for bed care. The figures—particularly those for the armed forces and the V.A.—are subject to some discount because of the practice of charging the hospitals with patients while they are out on pass, as it is possible to utilize to some extent the beds of such patients. However, in the surgical procedures listed above, this discount would not be as much of a factor as in cases requiring prolonged convalescence.

Factors in these startling differences in length of stay include the following:

1. Federal hospitals give convalescent care. In military hospitals 75 to 85 percent of the patients are ambulatory.

2. In voluntary general hospitals, the economic pressure of cost to the patient, and the demand by the hospital for beds to serve others, hold the average stay down. Also improvements in professional care

have significantly reduced lengths of stay in recent years. This both makes for much more efficient utilization of beds, holds down real costs and increases the volume of cases treated by scarce specialists. But this has not occurred correspondingly in Federal hospitals where economic motives operate in reverse to lengthen stays, and there is obvious indifference on the part of management in many cases to make optimum use of facilities.

3. Some part of the difference is due to hospitalization far from the patient's home.

4. Many patients are admitted to Federal hospitals with less thorough determination that hospitalization is needed. Patients are admitted and diagnostic procedures then performed; many of these could be done in an outpatient service or otherwise without the patient being in the hospital.

5. Stays are lengthened because the medical staff is not ready, the results of diagnostic or laboratory procedures are not completed or because the appropriate consultant will not make his periodic visit until sometime later. In community hospitals, the patient is generally only in the hospital when he needs to be there and when the hospital is ready to serve him.

6. Another factor often seems to be a desire of certain agencies to maintain hospitals in operation, and therefore to maintain a good census as a basis for personnel and other allocations.

7. Administrative procedures for discharge of patients, particularly in military hospitals, cause patients requiring no attention to be retained two to three weeks at times in Army hospitals. This is reflected in the fact that such patients are in hospital twice as long as civilians in the same institutions with the same diagnoses.

8. Stay in voluntary hospitals has been materially shortened in the last few years by early ambulation of patients, especially surgical and obstetrical cases, who are urged to get out of bed and even out of the hospital at the earliest possible date. Apparently, this development has not been widely accepted by Federal hospitals or at least their length of stay experience does not reflect it.

This analysis shows that stated requirements for beds in Federal hospitals and especially for military patients could be very greatly reduced. Since Federal hospitals now cost $20,000 to $40,000 a bed to build, such traditional easy practices of utilization are no longer ac-

ceptable. This is especially so since cutting the length of stay means that the same medical staff can take care of many more patients, reducing the shortage of doctors.

E. Spotlight on Medical Manpower

While there may be some controversy over the question of an overall shortage of doctors in the country for peacetime needs, it is beyond dispute that such a shortage exists in the Federal government. Its seriousness is stressed by the reports of two of our subcommittees. Our Subcommittee on Armed Forces Hospitalization (Chairman, Dr. Hawley) was forcibly led by its study to identify the acute professional manpower shortage as the core of its problem. The Subcommittee on Medical Manpower (Chairman, Dr. Churchill), appointed to deal specifically with professional manpower, started from an entirely different approach and reached the same conclusion. Its findings document and corroborate those of Dr. Hawley's subcommittee. These conclusions were in turn supported by the findings of the task forces on tuberculosis and neuropsychiatry, already cited.

Considering first the military services, we adopt the following from the report of our Subcommittee on Armed Forces Hospitalization:[1]

> . . . The provision of adequate medical care for the armed forces has now become a matter of the gravest concern. . . .
>
> The numbers of doctors in the medical services of the armed forces is numerically insufficient at present for them to meet all of their responsibilities; and their shortage in medical specialists is much more critical. A large proportion of their present medical officer strength is made up of young physicians whose medical education was subsidized, in whole or in part, by the A.S.T. and V-12 programs of World War II. These young gentlemen have received excellent general training, but no specialist training of a scope to qualify them in these fields; and their experience is necessarily limited by their recent graduation. . . . at present their skills fall far short of the expertness demanded by modern medical knowledge.
>
> Furthermore, these young physicians are now serving under compulsion, as a partial return for the Government's contribution toward their education. Their terms of service will expire not later than 30 June 1949. This will create a still greater shortage of medical officers—a paralyzing shortage. Voluntary recruitment has thus far failed to fill present vacancies, and assuredly will fail to replace the excessive losses of the next six or eight months. This is an incontrovertible fact.

[1] Report of Subcommittee on Armed Forces Hospitalization, Appendix F.

The general Selective Service Act will produce but an insignificant number of physicians for the armed forces. The upper age limit and the several grounds for exemption will exclude all but a few.

The only remaining alternative is a special draft of physicians, and it is generally accepted that this will be necessary if the armed forces are to be given any kind of care. . . . The pool of eligibles from which physicians could be drafted is limited almost entirely to recent graduates of limited training and experience, wholly unqualified to assume the heavy responsibilities of a modern first-class medical service; and the number of qualified specialists left in the medical services is woefully inadequate for the proper supervision and training of these fledgling doctors.

Under the existing pattern of military medical practice, and with the medical talent now in sight for this duty, it is certain that the quality of medical care is certain to drop even if the strength of the armed forces is not augmented.

This serious problem of the present, however, becomes critical with the operation of the Selective Service Act. Thousands of young Americans are to be compelled to serve in the armed forces. It may be accepted that these young men, their families and their friends—a number comprising a large proportion of our population—will expect and demand for these inductees a quality of medical care no less than that given the armed forces during World War II. The slightest relaxation of this standard is certain to produce serious repercussions; and a significant departure therefrom may well threaten the very security of the nation through repeal of the Selective Service Act. . . .

It must be accepted then, that, unless such expert medical skills are—in one way or another—made fully available to the sick and injured of the armed forces, thousands of young Americans will have been forced from their homes and vocations to serve a Government that is indifferent to their welfare. This is not a pleasant thought, but it is the truth.

. . . voluntary recruitment has fully met the medical needs of our armed forces in all our wars. . . . However, in World War II the interplay of the factors . . . made this solution barely tolerable for the civil population. The country was most fortunate during those war years in escaping both epidemics and enemy attack upon the civil population. Had either of these contingencies occurred, those at home would have suffered from lack of sufficient medical care. With the rapid development of new weapons for total war, the medical needs of the civil population must henceforth be given much greater consideration in the distribution of medical resources in war. . . .

These convincing facts point only to one conclusion—that, if adequate medical care is to be given the armed forces, the services of expert medical and surgical specialists must be made available in some way other than by induction for full-time employment. There is no other solution.

This appraisal of the condition in the armed forces is irrefutably corroborated by the detailed analysis of the Subcommittee on Medical Manpower.[1] The highlights of the findings of this report, which we adopt, include:

> No single agency of the Government now has the manpower resources in sight to enable it to meet its full responsibilities for health and medical service.
>
> This critical situation is neither temporary nor self-correcting. Vigorous measures to meet this condition during the past three years have produced fragmentary and inadequate results.
>
> When improvement has occurred, as in the case of V. A. through Public Law 293, the benefit to that agency has been achieved only at the expense of the others.
>
> The armed forces have been able to meet these responsibilities only by the obligatory service of A. S. T. P. and V-12 trainees during the war.
>
> Quality of medical service is equally if not more important than quantity and is derived from an integration of general medical care with specialist services. Technical skill and competence in medicine are synonymous with specialization.
>
> Present and prospective personnel deficits are so serious as to show that the workload is greater than can be maintained.
>
> The workload must be examined against the prime needs of each agency for supporting medical service, and when recruitment has failed we must examine whether a primary function of government is jeopardized to the extent that conscription of doctors is necessary.

The report of the Subcommittee on Medical Manpower documents the shortages of the different agencies in professional manpower, showing the appalling gap, quantitatively and qualitatively, between availability and requirements under the present system. In the Army and Air Force, taking surgery as an example, we estimate an over-all deficit in surgeons of about 25 percent on 1 October 1948, and at least 40 percent on 1 July 1950. However, this fails to reveal the true shortage. When analyzed for differentials of training and experience, the anticipated shortage on 1 July 1950 becomes 77 percent in board certified or equivalent surgeons. Thus, it is not only a numerical shortage but, even more important, a qualitative shortage.

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[1] Report of Subcommittee on Medical Manpower, Appendix G.

In the nation as a whole, one doctor out of every six or seven is a specialist, certified by the appropriate board; in the Army the ratio is one to thirty-three.

The Division of Psychiatry and Neurology of the V. A. has recommended against constructing any more neuropsychiatric hospitals, except in medical centers, because of the inability to staff them.

Medical care in the V. A. has been maintained through the past two years only because its staff was augmented by loan from the Army and Navy of 1,500 A. S. T. P. and V-12 doctors. These men completed their obligatory service this year and there is no further supply from this source.

In the V. A. hospitals, problems in staffing have a close relationship to location of the hospitals. Some relief could be secured if, as the V. A. Department of Medicine and Surgery has strongly recommended, hospital construction is concentrated in larger cities in which part-time medical and ancillary personnel could be recruited without undue sacrifice to private practice and teaching connections.

The Federal agencies as presently organized have no means of coping with the manpower shortage, other than measures which accentuate the competition among themselves and with civilian institutions. These facts emphasize that a cardinal weakness of the present Federal organization for medical care is its failure to provide for coordinated personnel planning, procurement and utilization.

Further, the Federal agencies make poor utilization of their physician personnel. Earlier studies have shown that the doctors themselves feel this strongly and are resentful of it. Our surveys confirm both poor utilization and doctor resentment.

In summary, then, we found shortages of skilled medical personnel in combination with inefficient use of such personnel. The armed forces' proposal to draft doctors is necessary, but can be justified only for truly military needs. Only a major reduction in workload and radical organizational changes which will make for efficient use of scarce medical personnel will enable the Federal government to give medical care of high quality.

F. Spotlight on Definition of Those Entitled to Medical Care

Although not technically an organizational weakness, the lack of a clearly expressed congressional policy defining certain classes of beneficiaries is a serious inadequacy of the present organization. There is no clearly expressed statutory authorization as to whether the dependents of Army and Air Force personnel are eligible for medical care; nor any clear legislative authorization to plan compre-

hensively for the hospital care of veterans with nonservice-connected disabilities. Care for both these groups may be a proper function of government but such vast obligations should be undertaken only under a clear authorization by statute. It should be planned, not just happen.

A vast hospital plant has been created for purposes some of which are neither clearly defined nor authorized by any settled policy. The Congress must have intended to provide medical care to veterans with nonservice-connected disabilities in far greater numbers than could be accommodated in surplus beds in hospitals built for service-connected illnesses or it would not have built three times as many hospitals as are needed for the latter. But the V. A. at present can provide medical care legally for veterans with nonservice-connected disabilities only in Federal hospitals. Consequently, it cannot provide care to these veterans in the most economical way, which in many instances would be in the local hospitals of their home communities.

Further, veterans with nonservice-connected disabilities, not being clearly entitled to hospitalization, may have to wait weeks or months until beds are available. Moreover, they may not receive out-patient care even during the waiting period.

Under the provision that hospital care will be furnished for nonservice-connected disabilities on the veteran's statement without investigation that he is unable to pay (the so-called "pauper's oath"), many veterans whose needs are less acute may receive hospitalization while others, less financially able but more conscientious, may not be benefited.

Present practices are so loose that veterans are often considered to be unable to pay if the question as to ability to pay is left unanswered.

As a practical matter, the hospitalization of veterans is now limited principally by the size of the Federal hospital plant, and the desire of the individual veteran to seek hospital care under a statement of financial inability which is largely a matter of form. Ability to pay is not more than a very minor moral deterrent.

Summary of Weaknesses

Tested in these various ways, it is clear that the unsatisfactory conditions found are not sporadic instances of bad judgment nor administrative failure, but result from inherent weaknesses caused by the way in which the present Federal medical services have come into being, and the nature of the existing setup itself.

The foregoing facts are not offered as tests of the efficiency of the several agencies, which was not our objective, but as a yardstick by which to measure the adequacy of the existing governmental medical organization against the Commission's objectives. We conclude that it does not meet the standard so set. For the faults we have found, we blame primarily the competitive organizational climate in which the various agencies have striven to function and to maintain their existence, rather than the agencies themselves.

III. RECOMMENDED ORGANIZATION TO ACHIEVE THE OBJECTIVES DEFINED BY CONGRESS

The present numerous services concerned with similar medical activities must be integrated into *two major systems—military* and *non-military*. Before reaching this conclusion we considered carefully whether an agency in the Executive Office of the President might be able to secure effective coordination of the various independent departments and agencies in a way to remedy the serious defects which we have disclosed. It is, we feel, an impossible task to remedy these weaknesses merely by high-level efforts to coordinate independent and competing agencies. The manpower shortage is the conclusive, determining factor which convinces us of the inadequacy of this approach.

If consolidation is to occur, our examination shows that there is no existing Federal organization suited to absorb or supersede the others.

Proceeding upon the assumption which we were instructed to make that the Commission would recommend a Cabinet Department embracing health, education and security, we believe that such a department, including a National Bureau of Health, could remedy to a major extent the organizational weaknesses of the present setup, and give the leadership, direction and considered planning urgently needed and contemplated by Congress.

We, therefore, recommend for the *non-military system* the organization of a new National Bureau of Health, in the proposed new Department, to be headed by a professional career Director General. He should report directly to the Secretary, and should, in the non-military Federal organization, be the highest ranking physician in the Government. Since the appointment of Under Secretaries and Assistant Secretaries is of course not necessarily on a career basis, no physician should be appointed to such posts who would come between the Secretary and the career Director General. The supreme medical

importance of the position of the Director General should command, irrespective of all other considerations, the ablest medical and health administrator whose services can be obtained by the Government.

Our recommendation does not contemplate the creation of an additional government agency in the usual sense. It proposes using the facilities and resources of existing agencies. We do not believe that this change will result in additional expenditures; on the contrary, we are convinced that it will bring both great savings and an improved standard of care by better utilization of the limited manpower resources.

This Bureau should be manned by career personnel drawn initially from the various agencies whose functions are recommended for transfer to the new National Bureau of Health, supplemented by medical officers whom the armed forces shall have the right to detail for training and rotation as later discussed.

This brings us to the question of the main organizational units of the proposed new National Bureau of Health. It should consist of at least three main divisions: (1) Medical Care Division, in which would be gathered all of the functions of the National Bureau of Health with respect to hospitalization and other direct medical care of patients (discussed herein in Section IV); (2) Public Health Division (discussed below in Section IX); (3) Research and Training Division (discussed below in Section X).

Because our recommendations relating to the transfer of hospital and medical care functions involve other considerations and adjustments, they will be presented before we take up recommendations for the military system and its relation to the non-military. Medical supply, an ancillary but important aspect of medical care, will be considered in Section XIII.

IV. MEDICAL CARE FUNCTIONS OF THE NATIONAL BUREAU OF HEALTH

Unless we can bring to bear upon this question the informed and courageous approach which the Commission has asked of us, the efforts of this committee will be of little value.

Our conclusion is that the great body of the Federal functions, facilities and the personnel for medical care of patients should be transferred to a Medical Care Division of the proposed National Bureau of Health. These should include: (1) the general hospitals of the armed forces in the continental United States (except a medical center for each of the three services), and station hospitals (cer-

tain of which the Navy calls "dispensaries") in the continental United States except those at outlying posts so located that other hospitals of the National Bureau of Health would not be near enough to provide the hospitalization required; (2) the medical functions of the Veterans Administration *in toto,* including the out-patient services in the Regional Offices of the V. A.; (3) the hospitals of the Public Health Service; (4) St. Elizabeth's Hospital; (5) the four non-military hospitals in the Canal Zone; and (6) both the U. S. Soldiers Home in Washington and the U. S. Naval Home in Philadelphia.

On the other hand hospital functions which should not be transferred include: (1) the armed forces station hospitals above excepted, together with all armed forces hospitals overseas, (2) the hospitals of the Bureau of Indian Affairs, (3) the hospitals of the Bureau of Prisons, and (4) other small hospital functions such as those which are incidents of T. V. A. and the Atomic Energy Commission. The Indian and prison hospitals should, however, be completely staffed by professional personnel from the National Bureau of Health. We deal separately with Freedmen's Hospital.

Fully conscious of the radical departure from traditional functions inherent in this plan, and of the responsibility involved in recommending it, we have reached the decision to do so not only because of the vast saving in money which it makes possible, but because it is the only way in which high quality care can be maintained in the face of the Federal medical manpower shortage.

For an understanding of these proposals, it is necessary to state at this point that for this plan to function it must be accompanied by a clear definition of the rights of veterans with nonservice-connected disabilities and of dependents of military personnel, subjects which are later fully discussed herein. This plan presupposes that, based upon such new clear definition of the rights of these classes of beneficiaries, the resources in medical manpower and the facilities—where these are of satisfactory quality—of community hospitals will be utilized for care of Federal beneficiaries to whatever extent efficient operation indicates. *The principle should be that hospital care for Federal beneficiaries be planned in relation to the hospital resources of the country as a whole, not merely through construction of Federal hospitals as a class apart.*

It must be steadily borne in mind that assumption of Federal financial responsibility is an entirely distinct question from provision of such medical care directly in Federal hospitals only.

In these recommendations the two transfers of greatest moment are the medical services and hospitals of the armed forces and of the

V. A. In making these, we adopt the essentially identical conclusions of several of our subcommittees.

A. Transfer of Armed Forces Hospital Functions

Speaking first principally of the transfer from the armed forces, we cannot improve upon the following statement of Dr. Hawley's Subcommittee on Armed Forces Hospitalization.[1]

> In exploring the possibilities for more efficient use of the medical potentialities of the nation, this subcommittee early arrived at the firm conclusion that so much of a medical service as is in direct support of an armed force is, and must continue to be, inseparable from that force. The functions of a medical service are too diverse, and the responsibilities of commanders too inclusive, for medical personnel to be allocated and withdrawn solely on the basis of current need for medical care.
>
> There is at present, however, a function of medical service that is not one of direct support of an armed force. This is the purely professional care in hospitals of the serious cases requiring expert medical or surgical skills [specialists]. A high proportion of such cases are forever unfit for further military service; and such as do fully recover are of little military value during the period of their hospitalization. Such patients are primarily a medical rather than a military responsibility; and, while there are many sound reasons for not separating those of further usefulness from military control, there is no impelling reason for treating them in military hospitals.
>
> . . . The one major responsibility of the medical services of the armed forces that cannot be met adequately either by voluntary recruitment or reasonable compulsory service of physicians, then, is the operation of that class of hospitals that are capable of providing highly expert [specialized] care and treatment.
>
> Fortunately, a precedent for such solution has been established by the Department of Medicine and Surgery of the Veterans Administration. Faced with almost the identical problem, this Department obtained the services of hundreds of outstanding specialists upon a part-time basis. This program has been in operation for almost three years, and its success is no longer in doubt. Of the 91,290 patients in Veterans hospitals on June 30, 1948, the professional treatment of about 58,000 was given wholly by, or under the close supervision of, part-time specialists. To provide these services with full-time personnel would require the withdrawal of at least 1,250 specialists from the limited medical pool of the country. . . .
>
> These facts lead the subcommittee to the firm conclusion that an acceptable quality of medical care can be insured to the armed forces only by a radical departure from the traditional pattern

[1] Report of Subcommittee on Armed Forces Hospitalization, Appendix F.

of such care. The subcommittee is fully aware of the repercussions excited by any departure from tradition; but it is also conscious of the insurmountable obstacles that have recently come into the picture and which cannot be overcome in any other way.

First, the most economical use must be made of the limited amount of expert [specialized] medical talent in the nation. No longer can it be dissipated through exclusive allocation to one or the other Federal medical service, or even to the exclusive service of the Government. The needs of the civil population must be protected in war as well as in peace. To this end the part-time services of specialists must be utilized to the fullest extent in staffing the military hospitals of general hospital caliber within the Continental limits of the United States. Obviously, such a territorial limitation is necessary, but only because their services are not available elsewhere. These specialists on part-time must actually replace military medical men rather than, as at present, merely supplement numerically adequate staffs for purposes of instruction. They must be given responsibility for patient care as well as for teaching. . . .

. . . *Efficient and economical use by the Government of the limited amount of expert medical talent can be assured only through the establishment of a single system of Federal hospitals in which the bulk of the responsibility of the Government for medical care can be discharged. Such a system would effect great economy in hospital plant as well as in medical personnel of all categories; and it would least disturb the medical care of the civil population both in war and in peace.*

The scope of this Federal hospital system should include all of the responsibilities of the Government for medical care other than those that are inseparable from the armed forces and from other Government activities of peculiar nature. . . . This Federal hospital system should absorb all hospitals of the armed forces of general hospital caliber within the Continental limits of the United States (with the exceptions hereinafter mentioned), and the existing hospitals of the Veterans Administration, and the . . . Public Health Service. . . . The armed forces must retain military hospitals of station hospital and naval dispensary caliber and less, within Continental United States only where other Federal hospitalization is not available, and all military hospitals beyond the Continental limits of the United States. In addition, for purposes of training and research, the Army should retain the Army Medical Center, the Navy the Naval Medical Center, and the Air Force should be permitted to construct an Aviation Medical Center.

If and when created, this Federal hospital system should follow the pattern of medical staffing established three years ago by the Veterans Administration. The fullest possible use should be made of the faculties of schools of medicine, and of other expert medical specialists upon a part-time basis. These hospitals must serve the professional training needs of the armed forces, and permit the detail of commissioned medical officers and other

> military medical personnel to receive instruction. There is no reason why this proposed Federal hospital system should not be charged with the responsibility of all technical training of medical specialists and technicians for the Federal Government. . . .
>
> The care and treatment of military personnel in such a Federal system of hospitals need present no insoluble difficulties. The use of military registrars in the larger hospitals, and for areas in the case of smaller hospitals, will simplify the problems of records and of discipline. Separation of permanently disabled from the service at the earliest possible date can be arranged by mutual agreement upon policy.

Working entirely independently of Dr. Hawley's group, Dr. Churchill's Subcommittee on Medical Manpower also recommends (Appendix G) that, to correct the unsatisfactory conditions above described and secure optimum utilization of scarce personnel, the workload of the Federal medical service, except the part clearly identified with the primary missions of the armed forces, be consolidated in a single Federal agency.

One illustration of what this change would mean to the armed forces is that the shortage of board certified or equivalent surgeons in the Army and Air Force would be reduced from a deficit of 75 percent to only 35 percent as of December 31, 1948.

B. Transfer of Veterans Administration Medical and Hospital Functions

Implicit in the above plan is the transfer to the new Bureau of all medical and hospital services of the Veterans Administration, including out-patient services now provided through Regional Offices.

Veterans hospitals are by far the largest single group, have more than half the total bed capacity of all the Federal hospitals and are progressively increasing in size relative to the others. Were they to remain separate, the new Bureau of Health would be the Government's central health agency in name only. Under the direction of the statute and the instructions of the Commission to consolidate like services, this transfer is mandatory.

C. Basic Reasons for the Above Transfers

Before discussing transfer of other functions to the new Bureau, we pause at this point to state the advantages flowing from the above steps, without which we have been able to find no solution to the medical problem now faced by the Government:

1. It creates a hospital system in which armed forces personnel can be given specialist care not otherwise available.

2. Merging of the V. A. hospitals, those of the Public Health Service (later discussed), and most of the general, and some of the station, hospitals of the armed forces will create a unified hospital system which can consolidate facilities, make optimum use of scarce manpower and thereby provide a generally higher standard of care.

3. Priority of attention can be given to the groups to which the Government owes an unconditional and primary obligation—the largest of which of course are veterans with service-connected disabilities and personnel of the armed forces. Veterans with nonservice-connected disabilities and other contingent beneficiaries may be given care as Congress may authorize both in such hospitals and, to the extent necessary and desirable, in community hospitals under the comprehensive plan later discussed.

4. Hospitalization of patients will be possible nearer home. This, together with the development of convalescent facilities as an integral part of the system, should under proper management result in shorter stays in hospital, and effect a significant reduction in the number of Federal beds required for any given amount of patient workload.

5. The reduction in Federal bed requirements as a consequence of all of the above factors, and other reforms which such a management should effect, could avert much of the very costly new Federal hospital construction program now projected. For example, in the areas surveyed by the Subcommittee on Hospitalization—constituting roughly only one-sixth of Federal hospital beds in this country—it has been estimated that new construction costing upwards of $100 million in such areas alone could be saved by a unified Federal hospital system.

6. The greatest and the most vital saving of all would be in professional manpower. The hospital system as a whole would be an integrated one, with specialized centers, use of part-time specialists, and association with medical schools and teaching hospitals. By these and other techniques, scarce professional personnel could be conserved to the utmost, as is now being done as to physicians in those V. A. hospitals under Deans' Committees.

7. This plan also has great advantages should war occur as will be later discussed. (Section VIII)

8. Such unification is requisite to make satisfactory provision for the two great chronic diseases. The task force on tuberculosis reported that consolidation of existing Federal tuberculosis hospitaliza-

tion in a single agency is essential; that no new Federal tuberculosis hospitals should be built except those under construction; that as a long-range solution there should be a gradual transfer of more responsibility to state institutions for the care of Federal tuberculosis beneficiaries; that the Army and Navy should discontinue operation of tuberculosis programs of their own; that tuberculosis hospitals of the V. A. should be transferred to the new central hospital system.

Similarly, the task force on neuropsychiatry found that there should be a fusion of all major hospital and clinical services of the Federal agencies with "psychiatric centers" in general hospitals.

9. This hospital system would offer unique opportunities for the training of all types of hospital personnel, including military—executives, administrators, department heads, and all technical and ancillary staff. Nowhere else in the world would there be comparable opportunities for such training.

We now resume discussion of the remaining transfers to the new Medical Care Division.

D. Transfer of the Federal Security Agency Hospitals

1. Since the Public Health Service, together with the Federal Security Agency of which it is a part, would be merged into the new Department, its hospitals should obviously become part of the National Bureau of Health.

2. For the time being, St. Elizabeth's Hospital should also become part of the National Bureau of Health. Because it serves residents of the District of Columbia primarily, it is organizationally sound for it to become a part of the Government of the District. However, this must wait, in our opinion, until there is better assurance that the District Government will provide direction for it which will maintain the high standards now set by St. Elizabeth's in its special field. Under the unified hospital plan which we are proposing, Federal beneficiaries in St. Elizabeth's, other than residents of the District of Columbia, could then either be taken care of elsewhere in the Federal hospital system or in St. Elizabeth's on a reimbursable basis.

3. Freedmen's Hospital is a special institution to provide care for negro residents of the District of Columbia. It is also the teaching hospital for Howard University. It should be transferred to the University with such assistance in the form of appropriations as may be necessary for it to serve its purpose as an essential link in the plan for medical education at the university.

E. Transfer of Other Hospitals

1. The Army maintains in Washington, D. C. the U. S. Soldiers' Home and the Navy in Philadelphia the U. S. Naval Home, each of which has a small hospital. These are now entirely separate from the hospitals and domiciliary homes of the V. A. Since domiciliary homes of the V. A. would be transferred to the new National Bureau of Health as well as V. A. hospitals, it is clear that both the U. S. Soldiers' Home and the U. S. Naval Home should be similarly transferred.

2. In the Canal Zone the Federal government maintains four civilian hospitals, namely, Gorgas, Colon, Palo Seco (leprosarium) and Corozal. While outside the Continental limits of the United States, these hospitals would be more effectively staffed and operated if consolidated with the hospital system in the United States. Present day air transfer of patients would make it possible through such transportation both to achieve a better standard of care and substantially cut down the number of beds required and the standby capacity which it might otherwise be necessary to maintain. It would also terminate the isolation of these hospitals and thereby provide a better professional climate for them.

F. Basic Organizational Principles of the Hospital System

The hospitals should be grouped into regions, each so far as possible with a general hospital as its teaching and consultative center, and each under a regional director, reporting directly to the Director of the Medical Care Division, who should have the maximum amount of authority decentralized to him from Washington.

The regional pattern, set up by the Commonwealth Fund project and others, should be followed in making the medical center the focal point for the region. The hospital organization in each region should include not only smaller general and station hospitals, but also tuberculosis, psychiatric and other specialized hospitals and facilities for outpatient care in the area. Our tuberculosis and neuropsychiatric subcommittees are strongly in accord with this recommendation.

Under the above plan, the pattern of organization would be essentially vertical in character, with full authority in the Director of the Medical Care Division, under him in the Regional Director, and under him in turn complete management responsibility in each hospital director. Each hospital should have a single budget. The hospital director should prepare this and, upon obtaining approval of it, should be responsible for the expenditure of it.

It must be recognized that there is a dearth of trained and experienced hospital administrators for large operations. It is desirable that such administrators' qualifications should, if possible, start with a medical education. However, it is essential that such administrators adopt hospital administration as a career with medical education merely as a foundation for it. This is requisite because executive experience in a large enterprise is the basic qualification. Because of the shortage of medical directors qualified as above, it would not be possible in any hospital system of this magnitude to secure uniformly, or perhaps even in large part, medical directors for them. It must be recognized, therefore, that below the level of the Director of the Medical Care Division, who should be a physician, the positions in the hospital system might have to be filled in varying degrees by persons selected primarily for their executive ability and experience in hospital administration, even though they are not physicians.

Present Civil Service limitations would make it virtually impossible to obtain the right men for posts of the great responsibility required for the key offices of this division. We deal with these subjects later under Personnel Policies in Federal Medical Services, Section XI.

The above principles of direct management authority are violated extensively in the present Federal medical organization. The two largest units—V. A. and Army—have somewhat analogous systems. In the V. A., lay control by the Administrator includes decision, not only of what hospitals will be built, but also of the location. Both of these matters should be both initiated and finally decided by the highest medical authority in the agency. Further, V. A. hospital construction is an independent function not under the firm control of the Chief Medical Director. Naturally, hospitals so constructed do not fit medical needs, and involve unnecessary facilities and excessive costs. Architects, engineers and any other construction groups should be the agents not the masters. Because in the V. A. the entire field of "Special Services" is outside medical control, demands from this independent service, which may be foreign to true medical requirements, are included in hospital construction. Various veterans' organizations and other agencies are given extensive office space. Huge dining rooms, recreation halls, auditoriums and other expensive facilities are included. All these greatly increase hospital costs. Many are not essential for real hospital care in general hospitals.

In the recent history of V. A., these weaknesses are proving extremely expensive. Before the new regime came in, in 1945, certain hospitals had already been planned. Thereafter, additional hos-

pitals were planned, including various small peripheral installations, many of which had the approval of the Bureau of Medicine and Surgery, and others were located due to outside pressures. However, by the early part of this year at the latest, it had become apparent that for many of these hospitals it would be difficult, if not impossible, to procure adequate staffs. Had the control of construction been, as it should have been, under the Department of Medicine and Surgery, the construction program could have been adapted to the medical and hospitalization requirements and the manpower available. Instead, because of the rigidity of the organization and controls independent of the medical department, contracts have been let, and programs are going forward, which bear no sound relationship to the best medical treatment of veterans. We explain this condition in detail only because it is essential that it be understood in order that corrective organizational measures be adopted. It is one of the reasons on account of which the transfer of the medical functions from the Veterans Administration will mean a better standard of care for the veteran.

(Somewhat analogous conditions exist in the control of the Army hospital system, which we discuss later as part of the problems of the armed forces.)

But it is not only in the V. A. central office that this fragmented authority exists. The condition is equally serious in the field. In each region the Deputy Administrator is in charge of the hospitals in his area, not the Chief Medical Director or a regional hospitalization director responsible to him. In each, hospital management is in turn split into various mutually independent sections, so that the manager of a particular hospital has no over-all authority nor single supervision but reports in different fields of activity to different superiors.

Moreover, the outpatient services provided through the regional offices are not correlated with the hospitals. They have separate staffs with entirely independent and often duplicate equipment, and, by contrast with the better hospitals, deliver an unsatisfactory standard of care.

The outpatient services provided by the regional offices consist primarily of treatments to veterans with service-connected disabilities and the medical examination and evaluation of disability claims for pensions. The actual decision on disability or pension applications is made by the Claims Service. There is no real need for the medical and claims functions to be associated within the same organization because the medical services provided are nothing more than those

commonly purchased by insurance companies from private physicians, which is done purposely to get an independent evaluation.

With respect to the direct care provided by the outpatient service, as good or better care could be given through the outpatient departments of the hospitals.

As matters now stand, the personnel and outpatient activities of the hospitals are duplicated at least in part; the services lack the support of the highly specialized facilities and personnel of the hospitals; hospital personnel are not rotated through the clinics—nor vice versa—for the good of the patient and the training of the personnel; and the medical revolution which has made such remarkable progress in veterans hospital care has hardly touched the regional office outpatient clinics.

In recommending that the entire medical function of the V. A. should be placed in the new National Bureau of Health, we have had in mind the necessity for furnishing to the Claims, Insurance and Vocational Rehabilitation Services of the V. A., medical examinations, evaluations and any other medical support requisite. For this purpose, it is not necessary to maintain such medical services in the V. A. itself. The National Bureau of Health should be required, through the installations above described, to perform these medical functions for the V. A. The fact that the medical judgment in such evaluations would thus be an independent one is an advantage, not a handicap. Further, the integration of these outpatient departments with the hospitals would provide a considerably higher professional standard. The change would also correct serious weaknesses in the existing organization, previously pointed out.

V. INTEGRATION OF FEDERAL HOSPITAL SYSTEM WITH NON-FEDERAL HOSPITALS

The Government has been pursuing two mutually inconsistent policies in its aid to non-Federal hospitals under the Hill-Burton Act and in the V. A. hospital construction program.

Finding gross inadequacies in the nation's hospital plant, the Government paid part of the cost of hospital surveys in the states to determine real needs, and is now authorizing up to $75,000,000 per year in payment of one-third of the construction costs of hospitals found necessary by such surveys. The soundness of this step in promoting better national health is beyond question and the benefit derived from such carefully limited Federal expense is great. However, because hospitals operated by the Federal government are not

open to meet community needs, they were excluded from consideration in the survey.

Concurrently, the Federal government, without relationship to the Hill-Burton Act program, launched a new and greater building enterprise for veterans hospitals. These hospitals, under present policies, are in effect being built to give total hospital care to veterans who constitute about one-seventh of the population. But this one-seventh has been included—and correctly so—in the survey of community hospital needs. This obvious wasteful duplication in planning is but one of the resultant evils. More serious is the waste of spending $20,000 to $30,000, and in occasional instances over $40,000, per bed for veterans hospitals, of which the Federal government pays all, and for which it pays all operating costs, when the expenditure of a fraction of this amount in the communities in which veterans live (if added facilities are there required) could furnish hospitalization near their homes. Under an extension of the Hill-Burton Act, such aid to community hospitals might require a 50 percent Federal grant or a 33⅓ percent grant and an equal amount in long-term mortgage loan. Costs of hospital construction are now so high that even the vitality and energy of the community hospital system could probably not pay for two-thirds of the cost of construction, as is now required under the Hill-Burton Act. But these hospitals, which are constructed not as rest homes but solely for the care of really sick patients, can still be built at lower average costs per bed.

The economy of this approach is furthered by the fact that in many cases beds can be provided by additions to going institutions. The average bed cost of construction of general hospitals under the Hill-Burton Act up to a recent date—of which the Government has of course paid but one-third—is only $12,200. Since most of these are small hospitals of 50 beds or less and include considerable frame construction, they are of course not strictly comparable with the costs of new V. A. hospitals. But they do illustrate vividly how beds can be supplied at low total—and even lower Federal—cost, when the money does not come easily and every dollar is made to do an earnest day's work. They also make a rather startling contrast to the shocking per bed costs of various of the projected V. A. small hospitals, some of which are three times as costly. When V. A. hospitals cost per single bed as much as no one but a wealthy man can afford to pay for a house for himself and his entire family, a pause in such operations and careful scrutiny of them is called for. This is especially so when a clear, simple means of avoiding such vast Federal expense is presented, as it is here.

An even greater evil of the present plan is the injury to the community hospital system. Veterans' hospitals syphon off nursing and other scarce personnel. Such unfavorable competition between Federal and community hospitals is occurring at a time when the latter are already in great financial difficulties because of increased cost of operation due to inflation, which has caused threatening deficits for many of even the strongest.

The bald fact is that at the same time that the Government is spending up to $75,000,000 per year to build up community hospitals, it is in effect tearing them down by disastrous competition. At the same time, it is reducing their incomes by taking away a large class of patients who would normally come to them.

In the term community hospital, we include voluntary hospitals, state university hospitals, and county and city hospitals in smaller centers of population where these are in fact the hospital of the community.

The vital importance of community hospitals, not only for medical care in the country as a whole, but also specifically for Federal medicine must be clearly understood. These institutions, particularly the great voluntary teaching hospitals and the medical schools affiliated with them, have been and are the mainspring of modern medicine, the heart of research in medicine and the source of the very great progress in standards of care, length of human life and conquest of disease. It is in these hospitals that the undergraduate doctors obtain their clinical training and in which the graduates receive their residency training and become the specialists of tomorrow. Graduates of these schools and hospitals are the men from whom Federal medicine must obtain its own staffs and to whom it must look for further scientific achievements. V. A. hospitals which have been very recently affiliated with medical schools perform a comparable function, but their number is limited.

The voluntary hospitals of the country for a century have had, and still have, tremendous vitality. But heavy taxation of individuals and estates has reduced donations by preventing the accumulation of large fortunes such as those which created our great medical centers.

Costs of operation of hospitals have gone up faster than patient income; building costs have increased so that modernization to keep the plants abreast of the need is not possible. Recent surveys in several eastern cities indicate that at least 25 percent of the community hospital plant is so obsolete that it should be replaced at once. A substantial additional percentage is obsolescent.

The Hill-Burton Act initially attacked the desperate lack of hospitalization in rural areas. This was as it should be. All statistics prove that rural health and health facilities are inferior to those in urban areas. Therefore, most of the Hill-Burton Act funds to date have properly gone for smaller hospitals and additions in small communities.

But now the support should be directed toward the heart, as well as the periphery, of the community hospital system, with special emphasis on the teaching hospitals.

Both because the Federal policy of assisting community hospitals has already been recognized as necessary, and also because under proper planning such hospitals can aid directly in care of Federal beneficiaries, the over-all plan must consider them.

Local general hospitals are already staffed with the best medical talent in their communities. To the extent that facilities exist or are created, care of Federal beneficiaries can, therefore, be given without seriously intensifying the medical manpower problem. A formula already exists as a basis for the reimbursable cost for such care. While this does not include medical attention, for which rates and arrangements would have to be agreed upon, bases for this also exist, so that the problem presents no insuperable difficulty.

In summary, our appraisal of the present Federal position shows that we have, in essence, a veterans hospital system which has reached or almost reached the limit to which it can be staffed to give quality care; an armed forces hospital system which has greatly exceeded the limit which can be staffed except by draft (and a draft of doctors cannot supply quality but merely a quantity of junior doctors); and at the same time a community hospital system already staffed and attracting a steady flow of medical graduates; that the latter system is essential to teaching and research; and, finally, that it is already Federal policy to give it reasonable aid.

The solution is obvious—not to expand the Federal system, but to extend limited aid to the community system. This should be done by partial assistance in new construction for general medical and surgical hospitals, to at least the extent that is necessary to provide needed facilities for Federal patients, and to contract for such care in such institutions. At the present time this would have to be confined to general medical and surgical hospitals, because local facilities for the care of tuberculous, psychiatric and other long-term patients are now very inadequate.

On the negative side, the above program will eliminate or minimize the present destructive competition; on the affirmative side it will

provide needed care for Federal beneficiaries for which Federal manpower does not exist, and will further the policy of revitalizing the community hospitals. Aid in construction should, of course, not be given to an extent which would diminish the responsibility and initiative of private philanthropy for these institutions.

It should be made clear that we are not recommending a curtailment of the existing V. A. hospital plant, but merely that it not be enlarged. If a limit is placed on the size, such as we propose, the new system will not at any future time be as large as the V. A. alone will be in a few years if there is no curb on its expansion. The proposed new hospital system will also be much smaller than the Army hospital plant in the United States during the war.

We also clearly recognize that many community hospitals have not yet attained a high standard. These, of course, would not now be used for Federal patients. But the recommendations we are making will help to improve the weaker ones by modernizing their plants and increasing their opportunities for service.

We make the above recommendations because we believe that Federal medical services cannot be planned in a vacuum, but must be considered as part of a sound over-all hospital service for the nation. This can be done at a lower ultimate Federal cost, without aggravating the manpower problem, with the patients nearer home, and with shorter hospital stays, by a policy of stimulating private charitable enterprise in a manner consistent with the American way of life.

While valuable in peace, perhaps the greatest benefit from this plan would be the security which it offers if hostilities should occur as we discuss later.

In the above recommendations the entire program of hospital construction, both for Federally operated hospitals and non-Federal hospitals financed through the Hill-Burton Act, would be coordinated through one planning agency with due consideration of local conditions and regional planning.

Federal and state governments should sponsor local voluntary groups, representing the states and communities, to carry out the function of planning the hospitals of each state or subdivision. Federal and state funds should be contributed to the financial support of this planning group, but a major portion of the budget should come from the local communities.

Such state and local planning councils should not have responsibility for the operation of hospitals, but should be advisors to represent the interests of the community. They should be made up of

members representing the planning organizations of the community and should not be dominated by members with vested interest in the hospital service.

VI. NEED FOR RECONSIDERATION OF THE DEFINITION OF BENEFICIARIES

As has been pointed out above, there is now no satisfactory authorization and definition by Congress as to medical care of dependents of Army and Air Force personnel and veterans with nonservice-connected disabilities. So far as there are present provisions for care of these groups, it is requisite that the care be given in Federal facilities and by Federal personnel rather than through making supplementary use of local community facilities and non-Federal personnel.

We also consider in this section of the report Navy dependents, (because the three armed services must, of course, be treated uniformly as to such privilege) and merchant seamen. As to both of such groups the present statutory authorization for care is in clear form.

A. Dependents of Armed Forces Personnel

Medical care should be given by the armed forces to dependents overseas, as other medical facilities of acceptable quality ordinarily do not exist. The same applies to dependents at some camps and stations in this country in areas remote from large cities, where community facilities are not adequate. In both of these instances care of dependents is a necessary incident of normal maintenance of the armed forces.

We question the justification for drafting doctors from their homes and practices, where they are now meeting community needs, to care for dependents who may be in no more need of such care than are these doctors' own patients at home. Representatives of the medical profession have indicated that the profession will oppose such a draft.

It is impossible under present record keeping practices of the armed forces to arrive at a definite figure of the number of medical officers, particularly specialists, now required for dependents' care, although it admittedly constitutes a substantial share of the workload. Our Subcommittee on Medical Manpower, however, estimates that a saving of several hundred medical officers would be possible if such care were not provided directly by the armed forces. This could be done without depriving dependents of care, by adopting a policy of utilizing for them local community facilities and professional personnel wherever possible.

We recognize that provision of adequate care for dependents has been offered as an inducement to men in service as part of their compensation, and that to terminate it would be injurious to morale at a time when it is necessary to build up, not tear down, our defense structure.

If Congress determines that the equivalent of the present care of dependents should be supplied by the Federal government in all areas, it could be done by either of two methods. First, the Government might, as part of the compensation of members of the armed forces, contract directly for such service with local community facilities and personnel; this would be limited to hospital care in acute (not chronic) cases and to outpatient care. Second, if a non-profit or commercial health insurance plan is found to be available which conforms to the requisite standards set by the government, premiums for the dependents could be paid as part of the compensation of members of the armed forces. Such insurance should omit provision for care in overseas or other remote localities and the aggregate premiums adjusted downward accordingly, since care in these places would be provided by the armed forces in any case.

Either of such plans, apart from relieving the armed forces of a responsibility for which it is not reasonable to draft doctors in peacetime, has the advantage of bringing the cost of this item clearly into the budget. It represents the basically sound fiscal policy and true long-range economy of having all real costs budgeted for the purpose for which appropriated. So considered, medical care of dependents in this country generally is really an item of the compensation of military personnel. It should be budgeted and shown as such; not be a concealed subsidy in unknown amount. If such care is to be provided, which is for the Congress to define clearly, we recommend that it be furnished by one of the methods outlined above. We have considered and rejected as a substitute an increase in pay by an amount sufficient to meet a health insurance premium.

Because the present cost is unknown, no specific figure of the savings which might be effected by the change proposed is possible, but, if either of the methods we suggest is adopted and properly administered, the cost should not be more than at present.

B. Veterans with Nonservice-Connected Conditions

We do not consider it to be the function of a committee largely composed of professional medical members, presumably selected for technical qualifications, to determine the basic question of philosophy

of government as to how much the United States owes to those who fought to defend it. But a basic, clear decision must be made by the Congress.

At present the law merely provides that veterans with nonservice-connected disabilities may receive hospitalization if beds are available and if the patients are not able to pay, but it requires acceptance of the veteran's own statement under oath as to his inability to pay. Veterans' hospitals have been built or are now in the process of construction or authorization to make available 100,000 beds beyond the needs of veterans with service-connected disabilities.

1. Present Situation Unsound: We believe that the present situation is unsound, both for the veterans and for the Government:

From the point of view of the veterans' interest:

a. The patients with nonservice-connected disabilities now receive only hospital, not outpatient, care. It is not possible, therefore, to employ effectively preventive measures which might avert long chronic hospitalization, unfortunate for the veteran and expensive for the Government.

b. The present eligibility provision for the care of veterans with nonservice-connected disabilities is highly uncertain in its operation. Veterans, depending upon the nature of their disabilities or the area in which they live, may go on a long waiting list. The veteran has, therefore, no assurance of hospital care when he needs it.

c. Hospital care can be obtained only by taking the so-called "pauper's oath." This may be merely a form for many. But one effect is that many receiving care may be in much less financial need of this assistance than others who do not get it.

From the Government's viewpoint:

a. It is neither giving care to all veterans with such disabilities, nor is it effecting the economies of giving free care only to those who really need it.

b. It is increasing the cost of care by failing to provide early detection and treatment for chronic cases. For example, present knowledge is such that paresis among veterans could be prevented at small cost, whereas the present crop of 5,000 paretics in V.A. hospitals who must be cared for for life will have an ultimate total estimated cost to the Government of $200,000,000.

c. The present provision, whether or not the Congres intended it, leads to the snowballing-up of additional facilities for veterans' care, far beyond those needed for service-connected disabilities, because the

Government can make no intelligent over-all hospital plan, utilizing community hospitals wherever it proves efficient to do so. This is because, under the present provision, care can be given only if a Federal hospital bed is available.

2. Alternatives: To meet this unsatisfactory situation, an initial determination must be made by the Congress. First, it must decide as a matter of policy whether to assume full responsibility for the care of nonservice-connected disabilities as it now does for service-connected cases. As a practical matter, Congress has taken a very long step in this direction by its appropriations for constantly increasing the facilities of veterans' hospitals far beyond the present or prospective needs of service-connected disabilities, and by opening the hospitals to veterans without any inquiry into their need of free care. Therefore, the realistic choice open to the Congress seems to be between (a) providing hospital care for all or (b) making a real, not a nominal, limitation based on financial need.

a. If the Congress determines on a policy of complete hospital care for all veterans, there should be provision in the law which will make it possible to give care for nonservice-connected disabilities in non-Federal hospitals on a reimbursable basis.

b. If the Congress decides to limit care to veterans in financial need, provision for screening is necessary for acute cases. But this is not requisite in our judgment in chronic cases. We have noted above that in the chronic diseases, such as tuberculosis and neuropsychiatric illness, which now constitute some 60% of all V.A. hospitalization, the illness itself almost uniformly is so prolonged as to make the patient medically indigent. Non-veterans with such illnesses are also almost uniformly unable to pay for their care and are provided for in state, county or city supported facilities. On the basis of his experience as Chief Medical Director of the Veterans Administration, General Hawley estimates that in 98% of chronic cases veterans are really unable to pay for their care. It would be realistic, therefore, for the Government which is now contingently providing for these chronic cases only if beds are available, to assume generally and unconditionally the obligation to supply such care, thereby giving the veterans a dependable and self respecting protection against the spectre of the cost of a permanent crippling illness. On this basis, care for these chronic cases would not be given merely if a bed is available, but beds *would be* provided in Federal or community facilities.

c. We, of course, recognize as a third alternative that, if the Congress establishes a system of compulsory health insurance, the question

of nonservice-connected disabilities would be automatically eliminated, as they would then be provided for in the same way as cases of other citizens.

d. If the Congress should decide to limit care in acute cases to real financial need (alternative "b" above), it could make provision for aiding the veteran under voluntary insurance to secure at reasonable expense care for nonservice-connected disabilities in the following manner:

The insurance would cover hospitalization for acute nonservice-connected conditions up to three months, including both hospital expenses and professional expenses in hospital. This would be done upon payment of a premium—roughly $30 to $40 per year—by the veteran for such insurance if he can afford it. If not, the Government, after determining his inability to pay, would make the premium payment. If the premium is not paid by either the veteran or the Government, the veteran would not be entitled to care, except in emergency cases of a nature which no hospital would refuse. The premium would be calculated on an actuarial basis for which, it is now established, there is sufficient experience.

Such insurance might be effected through non-profit hospitalization insurance plans, provided these meet standards approved by the Government, or, if necessary, by the Government's writing the insurance itself and contracting for the service in local community facilities. We believe the former to be preferable. But if this proves impracticable, the second course is perfectly possible. A minority of our Committee, however, does not agree that it is necessary for the Government to provide the insurance or that it should do so. If it is done it would be purely voluntary insurance for hospitalization and doctors' services in the hospital, and only for beneficiaries to whom the government now owes a special obligation and is now rendering in its own facilities and with its own personnel free service upon application by the veteran.

3. Preventive attention: Both for the veterans and the Government's protection, the V.A. should be authorized to provide free outpatient care for tuberculosis, neuropsychiatric complaints and for syphilis. We mention these because they are, from the viewpoint of Government expense, the principal chronic diseases for which our committee considers that there is the best prospect of such preventive measures showing significant results. We must certainly avoid opening the floodgates to unrestricted outpatient care for all kinds of conditions, both because the cost and the facilities required would be enormous and Federal professional manpower does not exist to give such care. However, as the great group of veterans of World War II

grows older, care of chronic cases will, as we have seen, become an enormous Federal liability unless all possible steps are taken to control it. Therefore, as medical science may produce dependable tests which will make early recognition of other chronic diseases possible, or as it may develop specific remedies for them which, if employed in time, would avert long chronic illnesses, the National Bureau of Health should be authorized, upon determination to that effect to give outpatient care of essentially a preventive nature for them. Also, in addition to ordinary outpatient care for tuberculosis, the Bureau should be authorized to give chest X-rays routinely to veterans; in proposing this, we follow the recommendation of the chief of our task force and of our distinguished consultant in this disease.

C. Merchant Seamen

As to the rights of this group, the law is entirely clear. The question is whether it should be changed. At present, seamen employed on U. S. flag vessels are entitled to free hospital and outpatient care by the Public Health Service. Certain other similar groups, minor in numbers, have like privileges. Care is generally given in the P. H. S. Marine hospitals, but also can be afforded by contract with other Federal or non-Federal institutions and individuals. Seamen on foreign flag vessels may be given medical care in the Marine hospitals when accommodations are available, but only on a fully reimbursable basis. Accordingly, there is no real problem now as to this latter group. Since provision exists for payment, the care can be supplied in non-Federal hospitals.

As to seamen on U. S. flag vessels, we are informed that under maritime law the shipowner is liable to a seaman, who becomes ill or is injured during a voyage, to supply maintenance and care as well as wages to the end of the voyage for which the seaman has signed, and maintenance and care for a reasonable time after the voyage is completed.

A study of this subject incorporated in the report of the "Interdepartmental Committee to Study Workmen's Compensation for Seamen" (Senate Document No. 113, 77th Congress, 1st Session), dated September 17, 1941, states:

> As far back as 1798 marine hospitals were established for the benefit of seamen of the American merchant marine. Today there are such hospitals in almost every port of the United States and their facilities are available to seamen without cost. As a practical matter, the ship owner and his underwriter pass along their liability for medical treatment to the marine hospitals when-

ever possible. The courts hold the seaman must avail himself of the facilities afforded thereby, and cannot charge the shipowner with the cost of treatment privately obtained.

We question why the Government should supply without cost a service which the ship owner is legally obligated to render.

D. Priorities

Among classes receiving care, if there are not funds sufficient for all, first must come personnel of the armed forces, veterans with service-connected disabilities and other direct wards of the Government, to all of whom an unconditional obligation is due; next veterans with nonservice-connected disabilities, in real financial need, then those not screened for real financial need. Care for dependents of the armed forces is essentially a question of pay of military personnel. Care for Indians should be gradually transferred to the states. Merchant seamen should rate last.

VII. ORGANIZATION OF THE MEDICAL SERVICES IN THE ARMED FORCES

In recommending the transfer from the armed forces of all general hospitals in the United States and of such station hospitals as are located in parts of the country where other adequate Federal facilities exist, we have not been insensitive to its effect upon the medical departments of the armed forces and their internal organization.

It is basic that the armed forces must have supporting medical service subject to military control. A single service embracing military and civilian Federal medicine is not practicable.

In our studies of the armed forces we have exchanged information and ideas freely, and have worked closely, with the medical advisors to your Committee on National Security Organization, Dr. Howard A. Rusk and Dr. Richard L. Meiling. Although each committee retained complete independence in viewpoint and presentation, we have arrived at similar essential conclusions.

A. Unification and Armed Forces Medicine

If there were no considerations other than economy and efficiency to be taken into account, a unified medical service supporting the Department of National Defense would appear mandatory for the same reasons that dictate unification of civilian Federal medical services. However, the structure of military medicine must conform to the

organization of the National Defense Establishment. A unified medical service cannot exist in a vacuum in the Office of the Secretary of Defense with his duties constituted as at present (or limited to policy and excluding operations) and with three separate branches of service. Our Subcommittee on Armed Forces Hospitalization[1] states the essentials succinctly in language which we adopt, part of which we have previously quoted:

> The medical service of an armed force is a necessary and an integral part of that force. To separate it from the force is wholly or largely to destroy its usefulness. . . .
>
> . . . . so much of a medical service as is in direct support of an armed force is, and must continue to be, inseparable from that force. The functions of a medical service are too diverse, and the responsibilities of commanders too inclusive, for medical personnel to be allocated and withdrawn solely on the basis of current need for medical care.

We are assuming, in the absence of any change in the functioning of the Office of the Secretary of Defense, that at present each of the three forces will have its own medical service. We recognize that this involves some overlapping, increase in personnel, and additional cost. Medicine could follow a merger, but it is difficult for it "to merge" without one. However, the disadvantages of possible triplication may be minimized by the adoption of some of the measures which are suggested herewith.

B. Avoidance of Duplication in Hospitalization

The proposal to transfer general hospitals and most station hospitals in the continental United States to a single national hospital system will eliminate much of the existing duplication and conserve scarce professional manpower. The area surveys vividly show the greater efficiency that will result.

Overseas, the Secretary of Defense should assign to one of the services full responsibility for the hospitalization, and much of the outpatient care, of all U. S. personnel in each geographic area. This proved successful during the war; it should be done now in an even more systematic manner. This step would conserve scarce medical personnel and make optimum use of facilities. The service having greatest responsibilities in an area would be the natural choice for the task there.

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[1] Appendix H.

For example, the above plan would at once correct such a waste as now exists in Hawaii. Under it, either the Army or the Navy would be designated as the service responsible for hospitalization. One of the two modern hospitals now being operated by the Army and the Navy, respectively, is sufficient to care for all military personnel there. The other could be made available to the civilian community, with its ownership retained by the United States Government against the danger of war.

C. Organization at Secretary of Defense Level

Since coordination by consent is a very lame, slow, but withal an expensive horse to ride, strong control over medical policy must be exercised from the level of the Secretary of Defense. This should be by a Deputy—or preferably an Assistant Secretary of Defense—whose function would include armed forces medical service as a primary responsibility. He should be advised by a committee composed principally of civilian doctors of medicine, with dentistry also represented, together with the two Surgeons General and the Air Surgeon. With the advice of the committee, the Deputy should allocate available professional personnel among the armed forces, issue directives to correct duplication, assign areas of responsibility for hospitalization, make certain that no unnecessary station hospitals are maintained in the United States, and generally, acting with the full authority of the Secretary of Defense, coordinate the three medical services with the proposed National Bureau of Health.

The advisory committee should be organized with a small working subcommittee of the two Surgeons General and the Air Surgeon, to deal with many operational problems which should not require civilian advice or assistance. The full committee should act principally upon policy questions. Existing programs for residency training, concerning which there has been much question, and, assuming the passage of a draft law, the extent to which the drafting of medical personnel would be permitted, would be important matters for special consideration. Relationship with the civilian medical profession would also be maintained and strengthened by such a committee.

Medical supply, which we later recommend be made the responsibility of one of the armed forces, should also be under the general supervision of the Deputy to the Secretary of Defense.

D. Position and Functions of Surgeon General of the Army

The Surgeon General should have direct access to the Secretary of the Army and the Chief of Staff on important matters affecting health, medical care, and medical personnel.

The Army's relationships with the medical profession should be supervised by the Deputy and Advisory Committee to the Secretary of Defense above proposed, and should no longer be primarily an Army problem.

The Surgeon General has only splintered authority over hospitalization, medical care and medical and ancillary personnel because of the conflict between professional concepts on the one hand and the Army's emphasis on command responsibility on the other. In this country, the Surgeon General has no real control over station hospitals, and lacks complete freedom in management of medical personnel in the six Army areas. If the Surgeon General were given direction over the remaining station hospitals in this country, the personnel operating them and the general dispensaries (in general, the medical service except the so-called "attached medical") to manage as an integral unit, more efficient use of personnel and facilities should be possible.

In overseas theaters, the same difficulties in medical management exist, but the greater importance of command responsibility makes the problem more complex. However, the command authority of the theater is not jeopardized by the Surgeon General's exercising technical authority, with the right and duty to make inspections, and with the expectation that his professional advice, his judgment as to assignment of personnel, and medical policies, should, as a general matter, be accepted, upon the basis that he is the chief medical advisor to the Secretary of the Army and the Chief of Staff. Too great emphasis on command authority and insufficient attention to technical professional direction have been real weaknesses and should be corrected.

The Surgeon General of the Navy is in a sounder organizational position for the discharge of his professional functions. Testimony indicates that the Navy concept of command recognizes military command, management control, technical control and coordination control. The military commander of course has military control, but this is limited to matters inherently necessary to maintain command. The Surgeon General of the Navy has management and technical authority, under which he assigns personnel and manages the hospital system. Organizational difficulties which in the Army have been very serious have thus been overcome. Consideration should be given by the Army to changes in this direction.

E. Medical Service in the Air Force

Representatives of the Air Force testified before our committee that they did not desire general hospitals, but that they did wish to

recruit their own medical personnel. The present relationship between Army and Air Force medicine is not satisfactory. If a unified medical service in the armed forces were possible, there should not be a further split. But subject to the limitations above explained, and to the proposed plan for supervision from the Secretary of Defense level, we believe that the Air Force should be given the right to operate its own medical service.

F. Concentration on Basic Military Mission

Much greater effort should be expended in planning and preparing medical support for military operations, and relatively less emphasis be placed upon the care of illness and accidental injury occurring during peace. Between World Wars I and II, the latter function too largely occupied the Army Medical Department. An illustrative result was that the plans for cantonment-type hospitals initially available for World War II were essentially those left from World War I. Again, hospital administrators who were to command great institutions under unusual difficulties were largely Army doctors in middle life whose principal experience had been bedside care. Experience in the European Theater alone convincingly demonstrated the inadequacy of a large number of these men for such executive tasks, a failing which was not primarily their fault. It arose from inadequate long-range planning for war. We feel that there is a genuine danger that this weakness is recurring. It is accentuated by the shortage of medical manpower which has led to a concentration of effort on the recruitment and maintenance of a professional staff.

The report of our Subcommittee on Armed Forces Hospitalization states that:

> The most important responsibility of a medical service in peace is constant readiness to support its parent force in war. Our own military history indicates that this responsibility cannot be neglected without unfortunate effect in the next war. The exclusive employment during peace of a medical service of an armed force in the routine care of the current sick and injured no more prepares it for war than would comparable employment of fighter pilots in commercial aviation, or of infantrymen in municipal police forces, prepare them for war.

Easing the burden of current medical care by shifting elsewhere a large part of the general hospital care and some of that in station hospitals, will enable the armed forces to concentrate on their primary mission of preparing for war.

To this end medical officers should, after reasonable opportunity to arrive at a decision, elect whether to make their careers primarily in bedside professional care or in planning for war. The latter could be made a career with great promise and attraction, for these men would be the leaders if hostilities should commence, and would necessarily receive the most rapid promotions. They would be trained for such key administrative posts as chief surgeons of overseas theaters, surgeons of armies, and commanders of the great military hospitals. Their peace-time assignments should be calculated to serve these interests primarily. They should be kept in touch with the progress of professional medicine through refresher courses at the best hospitals from time to time. They should be detailed to important administrative posts, including that of director, in large hospitals in the proposed National Bureau of Health, to gain experience, and further develop the science of hospital administration. Their duties would include participating in the peacetime planning of the mobilization of civilian doctors. They would be the key executives of the military medicine of the future.

This expert competence in the administration of military medicine can be based only on familiarity with and respect for preventive medicine. The balance of military potential in war does not rest on firepower alone but on the control of communicable disease, the maintenance of health in a wide range of environmental conditions, the elimination of hazards peculiar to the machines of war, and the control of mental attitudes which lead to psychological disturbances and end in psychiatric disabilities. Military medicine should not only develop experts in these special fields but by vigorous research and development achieve the leadership that is its heritage.

Another alternative offered Regular Army medical officers should be a career in bedside care, including specialization in a chosen field. Continuity of assignment in that field should be assured, and a fair balance should be provided between overseas and Zone of Interior duty. Extensive training opportunities should be given in the best hospitals of the National Bureau of Health and in the three medical centers of the armed forces.

We have recommended that each of the three forces maintain a medical center, one component of which should be a hospital. The other components should be a center for post-graduate education in military medicine and a research institute occupied with medical problems identified with the primary operations of the force. If these objectives are to be attained, these centers cannot afford to impede their activities by a heavy workload of routine patient care. They

must free their research laboratories of procedures, once these have been developed and standardized. Educational responsibilities must be directed to the post-graduate level with particular emphasis on military medicine in its broadest aspects. The workload of undergraduate medical education should not be undertaken.

From a functional standpoint, therefore, it is our opinion that military medicine is in essence total medicine. Its scope is as poorly represented by the board certified specialist in a large hospital as by the general practitioner on an army post. In planning for war, it can be assumed that sufficient doctors will be obtained from civilian sources to carry the workload of both general and specialized remedial medicine. The emphasis of the peacetime medical service should be directed broadly toward formulation of the military aspects of medicine as a whole. This will be achieved by integration of experts from all special areas without undue emphasis on any one.

G. Medical Personnel

1. Draft of physicians:

No savings which can be produced by our recommendations will be sufficient in time or in quantity to avert the need for a draft of doctors. But it can be greatly limited. There is a pool of about 8,500 former A.S.T.P. and V-12 students who have never rendered any military service. They were protected from the call to war, were allowed to pursue their education for their chosen profession and received Federal support while so engaged. But they should be drafted *only for services truly essential to the primary mission of the armed forces.* If this pool is conserved, as it would be under our recommendations, this group can meet all needs of the armed forces for four or five years, unless war occurs.

After them, there should be drafted those who, while not in the A.S.T.P. or V-12 groups, were also deferred during World War II to pursue their medical education and those who may be deferred under the current draft because they are medical students.

The general principles set forth in the above discussion also apply to dentists.

Our area surveys, our manpower questionnaire study, and our review of hospitalization in the armed forces, have convinced us that the present medical personnel requirements of the armed forces are not justified in full. We believe that a thorough review of these requirements by the Deputy to the Secretary of Defense and his new committee should precede any draft legislation.

2. Resident training:

Programs of residency training which the armed forces are now conducting, insofar as these are operated in armed forces hospitals, should be discontinued except in the single medical center conducted by each service respectively.

Residency training for all the armed forces should be included as one of the functions of the non-military Federal hospital system and uniformed personnel should be received for such training. The armed forces should have the privilege of placing their personnel in the non-military Federal hospitals for rotation and training, including refresher courses. This would prevent armed forces' specialists from having unduly too heavy tours of duty overseas or being deprived of opportunities for study and experience in general hospitals with outstanding staffs. The presence of some uniformed personnel in the non-military Federal hospitals for these purposes would be and should be recognized as a true military necessity.

On account of the emphasis placed by the Army and Navy on residency training, our Subcommittee on Hospitalization made a special study of the subject (Appendix H). The conclusions of this committee, including the recommendations above, may be summarized as follows:

> Resident training is of indispensable value but the value is dependent upon quality rather than quantity; residencies in the V.A. hospitals are conducted under the committees chosen by the deans of medical schools and are carried out by fully qualified specialists in civilian life. On the other hand resident training in some armed forces' hospitals is unsatisfactory because the officers conducting it are not themselves in many cases adequately trained and because the civilian consultants do not supervise the training closely enough and are not sufficiently active. Further, resident training in the armed forces does not seem to be directed effectively toward the needs of the services. We find that there are in training on active duty status 10 percent of all obstetricians, 6.7 percent of all pediatricians, and 16.7 percent of all thoracic surgeons who are preparing to care for the entire population of the nation. As the personnel of the military establishment with all their dependents accounts for less than 2 percent of the total population, it appears that resident training has become seriously unbalanced and a goal in itself. It leads inevitably to measures designed to increase the workload in order to make the program successful.

Residencies also received consideration by our Subcommittee on Medical Manpower (Appendix G), with substantially identical conclusions.

It is clear that, in the arid post-war recruiting climate for medical officers, the device of resident training was seized upon as virtually the only means of attracting voluntary service. Although the armed forces started resident training in order to procure doctors, they found it necessary to add greatly to their patients to maintain their residencies in order to supply sufficiently diversified clinical material. Dependent care helped, but was insufficient, and about 7,500 bed credits were established for veterans.

Accordingly, this device for procuring additional doctors itself created a great additional workload which, in turn, necessitated more doctors, completing the cycle.

There are also extensive residencies which have been established by the armed forces for the training of medical officers in civilian hospitals. These officers receive full pay and other emoluments of active duty status but render no service to Federal patients. They are an extremely expensive addition. A very careful scrutiny of such policy in each specialty would be needed to see whether any, and how many, of these residencies should be continued after the armed forces have been given the opportunity to train residents in the Federal hospital system we have proposed. While training in the Federal system a resident has been estimated to be able to give the equivalent of from 50 to 70 percent of the patient care given by a full-time staff doctor. No such value, either in dollar or manpower saving, exists in residencies in non-Federal hospitals. Pending a close study, such residencies should be recognized as so costly that they are justifiable only as an emergency measure to fill a gap which could not otherwise be bridged.

In this discussion we are assuming that the armed forces' residency program is sound from the point of view of the armed forces' ability to continue to hold the residents after graduation. At present the residents merely obligate themselves, after completion of their course to serve one year or more for each year of residency training. If, as there seems strong reason to believe, and as both our subcommittees which considered the subject concluded, the total service rendered by recent recruits will not exceed their obligated service, the armed forces' residency program will be an extremely expensive device on this account also. It must be recognized, however, that the armed forces will continue to need specialists for overseas hospitals and for some station hospitals in this country and at this time we know of no better method of procuring them than to train them. But this should be done in the hospitals of the National Bureau of Health and the three armed forces' Medical Centers and, to the minimum additional extent necessary, in non-Federal hospitals.

H. Maximum Hospital Benefit and Length of Stay in Armed Forces Hospitals

The present doctrine of "maximum hospital benefit" should be abandoned. As our Subcommittee on Armed Forces Hospitalization stated, "It has been the policy for many years to retain all surviving disabled in service until they have received maximum benefit for hospitalization. Not infrequently this results in the retention of cases in military hospitals for one, two, or even three years after their military usefulness has ended." In explanation of this policy in the past, it should be remembered that, until the last three years, V. A. hospitals were unable to provide medical care of the same high quality as the military. More recently, the armed forces' residency training programs have tended to stimulate retention of these cases because they are desirable to furnish a wider variety of clinical material for such teaching.

In our view, these patients under the existing organization should be cared for by the V. A. The proposed new hospital system would eliminate the problem of hospitalization, but not that of pay. At present the patients are retained on active duty in certain cases because of the large investment in special training and experience which the Government has in some of them, from which it might be possible to get some small dividend in the form of future limited service. Also in part, they are probably retained because of added privileges in military hospitals. But the question is also a matter of compensation. As long as the patient remains in the hospital, he is on active duty and draws full pay.

If an officer is retired for disability, he draws three-quarters of base pay, which is roughly half of his total active duty compensation. It seems apparent that this is a significant factor explaining the practice of keeping officers for long periods in Army and Navy hospitals after they are of little prospective military value. It does not furnish a valid reason for such practice.

An adverse financial change also affects enlisted men when separated and transferred to veterans hospitals.

It is not our function to determine what would be an equitable financial formula for such military personnel when they ought to be separated but still require hospitalization. However, the length of medical care in military hospitals ought not to be determined by such considerations. It should be noted that it is equally important not to make the provisions for compensation while in veterans hospitals so alluring as to prolong stays there for financial reasons.

A considerable amount of retention on active duty is a result of the present disability retirement law, necessitating a final determination as to the existence of permanent disability. The British system does not require this and permits later reevaluation. We might profitably follow this example.

Under the policy of maximum hospitalization the Army and Navy both operate tuberculosis hospitals for patients who have little prospect of ever returning to duty and no prospect of early return. The Navy has recently announced the building of a new hospital with elaborate equipment for radiation treatment of cancer and is establishing a new psychiatric center in its Houston hospital. Treatment of patients of the above classes except in the acute period does not serve the primary mission of the armed services, and with the present and prospective shortage of medical personnel it is indefensible to draft doctors to care for such patients when there are excellent V. A. hospitals for them.

A basic change in policy is, therefore, recommended to separate patients from the armed forces as soon as their early return to active duty is found to be unlikely.

I. Average Lengths of Stay in Hospital

These are now excessive as above pointed out. They should be cut down to some basis consistent with real need for bed care. This will still be important in the three Medical Centers, in remaining station hospitals in this country and in all overseas hospitals.

SECTION VIII. HEALTH RESOURCES AND MANPOWER ALLOCATION IN TIME OF EMERGENCY

A. Requirements of Civil Defense

No reorganization of the national health structure should be proposed without considering its relationship to the planning for civil defense. For background material we have had access to the report on Civil Defense for National Security prepared and recommended by the Office of Civil Defense Planning, dated October 1, 1948, from which we quote:—

> To care for the civilian sick and injured in a war which reached into American cities would require mobilization, through Civil Defense, of all the facilities and manpower in medical and health fields.

> Wherever attack might occur there would need to be units of professional personnel trained and equipped for the unusual task of caring for the injured where the numbers might run into hundreds of thousands.
>
> Paralleling this medical care need, would be problems of public health: The measures to protect against disease; against contaminated water, milk and food; against the disease of animals.

Recognizing the need for central civil defense operational control in metropolitan areas, the report concludes that:

> Emergency conditions will not permit of delays in crossing municipal, county, or state lines because of difference of governmental entity in an area where municipalities are contiguous, boundary lines artificial, and the populace united in concert of purpose and needs.

Similarly, emergency conditions will demand that all hospital facilities in critical areas be pooled and placed under civil defense operation control. The single hospital system of the National Bureau of Health could move quickly in response to the needs of civilian authorities or, if the situation demands, martial rule. Under its unified administrative control, patient groups could be transferred at the first alert warning. Already closely integrated with other community resources, in time of emergency the common purpose could be effectively served.

In making recommendations concerning the structure of the Medical Care Division of the proposed National Bureau of Health, we have stressed both regional autonomy and close integration with voluntary medical services. Isolation of Federal medicine as something apart from the community is no longer tolerable either in peace or war. Developments since World War II show the need for dissolving existing barriers. Active participation or leadership in civil defense planning, to prepare a program of medical service for a war emergency to encompass the total needs of the country, will tend to bring further community of effort and purpose into our medical economy which would be required if war should come.

While hospital facilities can be improvised for emergency need, this is not so with medical manpower. The Civil Defense report expressly recognizes this problem in saying:

> Thousands of physicians will be required in the nation-wide program. Many of these men will need to possess special surgical or related skills. . . . Furthermore, they may be needed not only for service in their own communities but for duty with mobile medical casualty units which can be sent to the assistance of other stricken cities.

In addition, many of the country's younger physicians will be required for active duty in the armed forces. But to drain civilian areas of doctors for this purpose would necessarily throw an impossible burden of medical care on those not eligible for active duty because of age or disability.

Under emergency conditions, the distribution of medical manpower within geographical areas defined by civil defense authorities would necessarily be determined by the total needs of the area. Only in this manner could the requirements be met, and the services of specialists be utilized to the fullest extent. The individual doctor would thus be able to care for the maximum number of patients compatible with his physical endurance and specialized skills. Except for those mobilized for rock-bottom needs of military service or sent to the aid of stricken areas by civil defense, the doctor should be working in his own community where his efforts can be expended with the greatest efficiency. He should there also give as much care to sick and wounded military personnel as possible, and the system we have proposed makes this possible.

B. Manpower Allocation

The allocation and assignment of medical personnel between the civilian population and the military was a difficult problem in World War II. As we have noted above, Dr. Hawley's subcommittee reports that the solution was "barely tolerable" even though the country escaped both epidemics and enemy attack upon the civil population. Had either of these contingencies occurred, those at home would have suffered for lack of sufficient medical care. With the rapid development of new weapons for total war, the medical needs of the civil population must henceforth be given much greater consideration in the distribution of medical resources in war.

Difficult and unsatisfactory as must be any mechanism for the allocation of scarce personnel, for equally vital competing requirements, experience makes it obvious that in war some central direction must channel available personnel on the basis of respective needs. A plan must be in existence for immediate execution if an emergency arises. Its formulation should not be deferred. For successful operation there must be a single authority in planning and execution, which can speak in the name of the President and which is not identified with any of the claimant interests. A board or committee which includes the claimant interests may usefully advise, present their respective requirements, and make such adjustments and accommodations as prove possible by agreement. But a group which must depend upon agree-

ment among divergent interests cannot be charged with the formulation or execution of the plan. That way lies paralysis.

Either the National Security Act is not sufficiently definite or the action taken under it so far has been inadequate, for the plan that will be essential to the allocation of medical personnel in an emergency, so far as we can learn from the testimony before us, has not yet been formulated.

The evidence shows that medical manpower is one of the scarcest of the resources essential to the country in war. Its production cannot be increased in response to emergency demands. It cannot be stockpiled. A sound program of conservation centers on allocation and distribution in accordance with absolute requirements, not in response to claimant estimates of needs. Furthermore, plans based on precise calculated requirements must be in shape to be put into immediate operation on proper authorization.

Our experience shows that planning of this character needs an effective and independent staff not identified with claimant interests and equipped to find the facts and do its thinking for itself. This staff must both assemble factual data from basic sources and itself subject them to rigid analysis.

C. Medical Supplies

We note that the above cited report on Civil Defense proposes that the responsibility of procuring and maintaining medical and surgical supplies for medical phases of Civil Defense be assumed by the Medical Department of the Army. Regional depots are proposed to avoid costly deterioration of perishable drugs and biologicals. We deal with this in Section XIII covering "Medical Supply."

D. Greater Use of Ancillary Technical Personnel

In any future war the shortage of medical manpower would be so acute that national service of doctors, dentists, nurses, pharmacists, and all other ancillary persons trained in health and medical services would be essential. Special training programs for ancillary personnel in highly specialized Civil Defense activities related to this field are recommended by the civil defense organization. The leadership that should be exerted in this field by the National Bureau of Health is discussed in Section XI.

IX. PUBLIC HEALTH FUNCTIONS OF THE NATIONAL BUREAU OF HEALTH

The Federal public health organization is much less confused now than before the principal units were gathered together in the Federal Security Agency. A number of important public health activities are

still outside that Agency and perhaps should remain so in recognition of the importance of having the maximum number of agencies develop an active interest in health. It is equally important, however, that these activities be coordinated. Accordingly, we have not proceeded on the assumption that it was either necessary or advisable to draw all health activities under a single administration. We were, however, cognizant of some jurisdictional disputes and internal maladjustments.

All Federal public health functions and agencies, with the exceptions noted, should be transferred to the Public Health Division of the proposed National Bureau of Health.[1] Specifically, this includes:

1. From the Public Health Service, the Bureau of State Services, the quarantine activities of the Bureau of Medical Services, the Biologics Control Laboratory and the cancer control activities of the National Institutes of Health, and Offices of Sanitary Engineering and of Dentistry from the Office of the Surgeon General

2. The Food and Drug Administration.

We do not recommend the inclusion of the preventive medicine functions of the armed forces, the Children's Bureau, the Office of Vocational Rehabilitation, or meat inspection or other activities of the Department of Agriculture.

The most important functions of the Public Health Division will be (a) the administration of grants-in-aid to states and the provision of technical assistance and demonstrations, (b) the conduct of a clearing house of information on public health activities of both public and private agencies, including the conduct and sponsorship of research in public health problems, and (c) the establishment and enforcement in interstate commerce of regulatory standards for food, drugs, medical, sanitation, and other types of equipment used in health services.

Federal grants in the public health field have proved extremely useful. They have been to a great extent responsible for making full-time local health service available to more people (37 per cent in 1935 up to 72 per cent in 1946). Instead of retarding, grants have actually stimulated greater financial participation by state and local government in support of local health work. The Federal share of the cost of state and local health departments fell from 46 per cent in 1937 to 29 per cent in 1946. Both quality and quantity of public health workers throughout the nation have improved because of the training programs and Federal insistence on the merit system. The great majority of states are now active in health fields which were being neglected in 1935.

Health grants are now administered in twelve different categories by three Federal agencies. While the categorical approach has fostered

[1] Report of Subcommittee on Public Health and Preventive Medicine, Appendix I.

new programs and enlisted support from interested groups, many local health officers have found it difficult to organize balanced health programs adapted to meet varying local needs. Only because the disease problems have been so great in relation to funds available for attacking them has the overlapping been relatively small. It is recommended that grants be made on a general health basis and that further development of full-time local health units be fostered to provide the basic framework upon which the various special programs must be engrafted. The Federal structure for administering grants needs simplification and decentralization with minimum supervision of the states consistent with sound planning and administration.

Field representatives should be authorized to transact business with states under a policy of maximum decentralization. Field representatives of all Bureaus of the new cabinet Department should have offices under the same roof if possible and work under a Regional Director for the Department who would be responsible for "housekeeping" administration, general coordination, and for supervising joint fiscal and merit system audits. Specialist consultants in health should be assigned to specific research or demonstration projects rather than to the Regional Office, but should be available on call. Decentralization cannot work effectively without ample travel funds so that the central office may keep in close touch with regional offices and they, in turn, with the field.

While all of the grants-in-aid functions of the present Public Health Service should be transferred to the Public Health Division of the National Bureau of Health, there is a question as to whether the administration of all of the grants-in-aid now administered by the Children's Bureau should be transferred to the new Public Health Division. The history of the Children's Bureau has shown the great value of an agency with the broadest possible approach, so situated administratively as to be able to work for the best interests of the whole child in all areas of health, welfare and educational activity. It is the view of your committee that it should function as a staff unit directly responsible to the Secretary of the proposed Department rather than having its health and other functions split and united with the major component units of the Department. It is our view that it should conduct research directly and through grants, carry on training and demonstration programs, provide technical assistance to other Federal agencies, state and local governments and voluntary agencies, and set standards. In this connection, we are of course assuming to speak solely from the health service standpoint.

On the other hand, we have concluded that it would be administratively unsound to leave the administration of the grants for ma-

ternal and child health and for crippled children in the Children's Bureau indefinitely. In our view, in not more than three years these grants, which comprise integral parts of state and local health department programs, should be consolidated with the other health grants-in-aid administered by the Public Health Division, in a special grant unit.

We have no doubt but that the preventive medicine functions of the armed forces must remain within the control of the armed forces because of the obvious necessity of having the control located with the troops.

The meat inspection service now in the Bureau of Animal Industry should remain there. It is a service operated by veterinarians trained in animal pathology and should be associated with related operations. The control of animal biologics should also continue in its present organizational location. Other activities of Agriculture relating to human health should be coordinated with general health work of the Federal government, under the leadership of the Director General of the proposed Bureau of Health.

Numerous Federal agencies quite properly carry on health activities which should not be transferred to the new cabinet Department. Interest in health should be as broad as possible, but it is essential that responsibility for coordinating all Federal health work be legally placed in the Director General of the Bureau of Health. He should be more concerned than anyone else in mobilizing the health resources of the whole nation for a concerted effort. Work in the fields of nutrition, mental health, environmental sanitation, industrial health, the health aspects of housing, health education and international health is carried on by various Federal agencies and requires strong coordination by interdepartmental and interagency committees provided with proper secretariat. Such committees should assist in solving existing jurisdictional disputes over industrial health, milk inspection, hospital construction and stream pollution control. They should agree upon suitable divisions of work and prevent duplication and contradictions in policies and educational materials. Problems of rural health and the health of migrant labor demand approaches on a broad governmental front involving many Federal agencies.

The technical health personnel required for health programs operated by non-health agencies should be assigned from the proposed Bureau of Health to work under administrative direction of the agency to which assigned. Such assignments of commissioned officers from the Public Health Service to other agencies have demonstrated effectively the value of this coordinating mechanism.

The Association of State and Territorial Health Officers serves a very useful function in keeping the Federal government aware of state and local health problems; and the National Advisory Health Council should also be continued with coordinating authority over subsidiary councils functioning in special fields such as mental health and hospital facilities. The Bureau of Health should play an active role in the National Health Council to maintain liaison with voluntary health agencies and there should be close relationships with professional organizations.

The need for intensifying our activities in preventive medicine and public health is discussed later in Section XV.

X. RESEARCH AND TRAINING IN THE NATIONAL BUREAU OF HEALTH

Research and medical education are inseparable in any really broad medical program.[1] We, therefore, recommended a Division of Research and Training. This Division should have cognizance of all the activities in research and medical education which are appropriate to the Bureau's huge program of direct medical care, and should administer those which are dictated by its broad responsibilities for the health of the nation. Medical research, oriented toward military problems, whether basic, applied, or developmental, should continue under the control of the armed forces. Similarly, the classified program of the Atomic Energy Commission must be separate. Because of their intimate relation to its primary mission, research activities of the Department of Agriculture related to health should also remain undisturbed.

In research there is need for a certain looseness and flexibility of administrative control. By their very nature, research activities are directed at new solutions and are easily stultified by rigid controls.

They must have a large measure of autonomy if effective, imaginative work is to be done. A certain amount of duplication here is scientifically desirable. Such budgetary controls, coordination of effort, and broad planning as may be necessary to fulfill the responsibilities of the Division, therefore, should not prejudice the maintenance of a large measure of autonomy at the level of the man with the ideas.

But some coordinating mechanism is needed under which research activities truly vital to national welfare may be considered. The armed forces have such a coordinating body in the recently appointed Committee on Medical Sciences of the Research and Development Board.

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[1] Report of Subcommittee on Medical Research, Appendix J.

We first recommend the establishment of a similar Committee on Medical Sciences for the continuing study and coordination of medical research activities of the non-military Federal agencies, consisting of representatives of the Division of Research and Training of the new Bureau, of the Atomic Energy Commission, and of the Department of Agriculture.

Secondly, we recommend that representatives of this new Committee, together with those of the Committee on Medical Sciences of the Research and Development Board, be appointed to a new Inter-agency Committee on Medical Sciences to review the broad programs of all Federal agencies as a whole. The duties of the Inter-agency Committee on Medical Sciences should relate less to the intramural programs, where autonomy should be virtually complete, than to the programs of contracts, grants-in-aid, and institutional grants to non-Federal institutions. The agency programs of the latter type must yield some measure of autonomy in favor of cooperation and coordination directed at insuring not only economy, but also the broad coverage which the entire Federal program must have.

When the National Science Foundation shall have been established, the Inter-agency Committee should include representatives from the medical sciences unit of the Foundation.

We recommend the creation of a National Science Foundation, not as a specific organizational reform in the Federal medical service, but as an obvious means of insuring the strength in basic sciences upon which our national security rests and upon which the future progress of scientific medicine depends. Some members of our committeee feel that the Foundation should cover the social sciences as well; others stress that it should include lay members. Our concept of a Foundation, it should be pointed out, calls for very great powers and resources to sustain and, where necessary, to increase the output of basic scientists, to develop new fields of knowledge, and to support educational and training institutions. We visualize no change in the responsibility of the proposed Division of Research and Training after establishment of such a Foundation.

The proposed Division of Research and Training should include among its activities direct conduct of laboratory and basic research, administration of grants-in-aid programs, and maintenance of a clearing house for research information. Behind these functions should lie an over-all responsibility for planning an integrated research program for the Bureau with the advice and recommendations of the operating divisions. Budgetary control of funds should rest with the Division of Research and Training. This does not mean that there

shall not be, incident to such functions as medical care and prevention of disease, research outside this budget. Such autonomy at the level of the research worker is essential but it should not be extended to major expenditures of public moneys.

The laboratory and experimental work presently carried out in the National Institutes of Health would be transferred to the Division.

Clinical research is a more complex problem. For the most part it would be done in hospitals under the proposed Medical Care Division. Yet the Congress has recently authorized construction of a Clinical Research Center for the combined clinical and laboratory investigation of cancer, mental disease, and cardiovascular disease. Under the principle of autonomy, the individual hospitals of the proposed Medical Care Division would have their own independent funds to the maximum degree thought wise by the Director General and his advisors. They would engage in research as an inseparable part of teaching and good medical care with provisions for only local review of individual projects. The Medical Care Division would exercise budgetary control over relatively small allowances to individual hospitals in the light of their special needs and accomplishments, within such over-all policy as the Director General should prescribe, but would not operate its own separate research section. The Division of Research and Training should retain responsibility for the allocation of major funds to individual hospitals and for developing projects involving a number of hospitals. It should also provide necessary leadership in promoting small-scale projects within the jurisdiction of the individual hospitals, as new fields of investigation open up or strategic opportunities remain unexploited.

The Division would operate the proposed Clinical Research Center of the Public Health Service. The chief of the Division and the Director General should know and consider that many experienced non-Federal educators and investigators are apprehensive lest the staffing of this great Center so deplete the personnel of existing non-Federal institutions as to be detrimental to the medical economy of the nation as a whole. If these fears prove justified, the rate at which construction, operation and staffing of the Center shall proceed should be so adjusted as to avoid it. In the interests of research efficiency, the work of this Center should be coordinated with that of other clinical centers in the Medical Care Division to promote efficient medical care and maximum utilization of specialist personnel.

The research grants-in-aid program of the Public Health Service, now under the National Institutes of Health, and of corresponding functions in the medical Research and Education Service of the V. A.

should be transferred to the new Division. The consolidated program should serve the broad research purposes of the Bureau and pertain to all types of medical research. It should include projects for which Federal facilities are inadequate or non-existent. This should be pursued as a permanent program, not as a temporary solution for a mere shortage of Federal facilities. To build up within the Federal government a research potential of sufficient size to meet the full research needs of the Bureau would be at the expense of well-established non-Federal centers of investigation, and would have far-reaching, damaging consequences for the medical economy of the nation.

We recommend, not only that an extramural program be continued but also that emphasis upon project research, financed by grants-in-aid and contracts, be changed in favor of a more sustaining type of support. Despite the invaluable aid which these programs have afforded to the medical schools during the post war period as the exclusive means of supporting extra mural research they have marked disadvantages. We recommend that more use be made of long-term grants for long-term projects and institutional grants, including funds for construction, directed not at narrow, carefully delimited projects but at larger problems to be attacked from various points of view and over longer periods of time.

The clearing-house function would have essentially two parts: (1) collection and dissemination of information about and emanating from various research projects, whether or not they are under Federal aegis; and (2) maintenance of a nation-wide inventory of medical research and facilities by location, type, and sponsorship.

We recommend further that the design of broad research programs, the choice of investigators and of institutions, and the review of research proposals be referred to appropriate non-Federal experts for advisory opinion, but without diminution of the responsibility of the Director General. Such formulation and review should pertain to the broad research policies of the Bureau, to the expenditure of major funds for intramural research, and to the disbursement of all funds for extramural research. The advisors must have not only scientific competence and general wisdom but also complete independence of Bureau ties and obligations. At least two successful patterns now exist for providing such advisory services and, although we do not recommend any particular pattern, we do recommend that, before deciding upon his advisory bodies, the Director General request and consider advice from the National Academy of Sciences.

Investigations in public health methods, epidemiological research, surveys of the nation's health, vital statistics, and the establishment

of general bench-marks to guide public health activities, should be under the complete control of the Division of Public Health.

The educational programs would also be varied. In addition to whatever may be appropriate for the educational arm of an organization with such great responsibilities for medical care and investigation, the Division of Research and Training would have a fellowship program along the lines of that presently conducted by the Public Health Service, would administer whatever aid to the medical schools the Congress might decide to give, and would be administratively responsible for the present Army Medical Library (for which a new building is urgently required). This latter would become a national medical library. An advisory committee on professional training and education would be essential to the proper exercise of these responsibilities. It may be noted that we do not recommend transfer of the Army Institute of Pathology, which should remain in association with the Army Medical Center. The fellowship program of the Division to help meet the acute shortage of trained and experienced workers in the medical and biological sciences should supplement the endeavors of the National Science Foundation and not compete with it.

XI. PERSONNEL POLICIES IN FEDERAL MEDICAL SERVICES

A. A Single Type of Career Service is Requisite

In a merger of Federal civilian medical services, there would be drawn together V. A. medical personnel employed under the special V. A. statute P. L. 293 (under which such employment was lifted out of Civil Service), commissioned personnel of the Public Health Service, and all medical professional personnel employed under Civil Service by the new Bureau. These groups should form the nucleus of a single new career service. It would be impractical to make this a commissioned corps.

The Civil Service has never functioned effectively in providing an adequate professional career service for medical and ancillary personnel partially because of its relatively low salary levels and partially because of its rigidity, slowness, and lack of opportunity for promotion. P. L. 293 was a long step in the right direction and it should be the framework for the new service. We checked this matter with the Personnel Management task force and were informed that such a plan would not be inconsistent with its recommendations. Civil Service medical personnel should, where properly qualified, be taken into the new service in the same way that Civil Service medical personnel of the V. A. have been absorbed. Members of the commissioned

corps of the P. H. S. should be given the option of positions in the new service or of continuing in their present commissioned status, but no new commissions should be issued.

It should be recognized, however, that part of the present success of P. L. 293 has been due to its more generous salary scale, as compared with those of Civil Service, the military and the P. H. S. commissioned corps. Also it is in part due to the fact that there have been substantial numbers of vacancies in the higher grades in the V. A. which, for the present, permit rapid promotions. This will obviously no longer be the case once the upper grades are filled and if a rigidity comparable to that in the Civil Service makes its appearance. P. L. 293 is particularly deficient, however, in its provision for qualitative selection and regular advancements, both of which are essential for effective personnel administration of health services. Its provision for 25 percent additional salary for specialists in clinical medicine, while useful in a program that is largely clinical in character, would be inequitable in a general health program. Specialists are not clearly defined in the fields of preventive medicine and research, although physicians and other professional personnel in these fields must have at least as much postgraduate training and experience as clinical specialists. Most non-medical professions have no ratings comparable to specialists. The term "specialist" has no relation to competence in many of the health professions. Since the health agency will employ thousands of non-clinical medical and non-medical personnel who will have no opportunity for certification as specialists, it appears that payment of additional salaries to clinical specialists would create serious morale and administrative difficulties among the personnel engaged in non-clinical work who are fully as essential in a general health program as are the clinicians. It would seem advisable instead to provide additional promotion credits or advance appointment credits for individuals of all health professions who possess advanced or post-graduate training.

Of particular importance in P. L. 293 are the liberal and flexible provisions it makes for the employment of part-time civilian specialists utilized not only for consulting and teaching purposes but for actual participation in the treatment of patients. This measure represented a real advance, and has contributed immeasurably to the success of the new regime in the V. A. It is essential that similar provisions be made as to the terms and conditions under which civilian specialists may be employed for the new service.

The modernized and improved personnel system (P. L. 725, 79th Congress) of the Foreign Service of the State Department should also

be considered in planning the new personnel system for health service. The Foreign Service represents an excellent combination of the good features of the commissioned corps system, with its regular promotions and career character, and of the classification system with its rewards of higher pay for more responsible positions.

Both features would be important in a health service and rank in that service should, therefore, relate to the individual as well as to the job. On the one hand, regular promotions are necessary, especially in clinical medicine and in research, because professional personnel may steadily increase in value to the organization while performing the same type of work over a period of years without any increase in administrative responsibility. On the other hand, advancement in status and pay must also be possible as incentives for acceptance of increased administrative or supervisory responsibility. Temporary or "spot" promotions for personnel while they are filling particular jobs (regardless of the regular rank) are also important.

The importance of the work and the tremendous responsibility which would be carried by the Divisions we are proposing make it impossible for such an organization to be satisfactorily staffed under present Civil Service salary schedules. We make no specific proposals with respect to salaries because we are informed that the Commission's task force on Personnel Management is studying and making recommendations for a revised salary scale which will make it possible for the Federal government to attract and keep high level professtional and medical administrative personnel.

The new system should put into the hands of the National Bureau of Health the full responsibility for recruiting, selecting, assigning and otherwise handling its own professional personnel.

It should be possible to detail personnel from the National Bureau of Health to any other government agency, Federal or local, as well as to non-profit private institutions and agencies. To facilitate detail to the armed forces, a simulated rank should be prescribed by law to personnel assigned from the Health Bureau to the military.

It is essential also to consider carefully the status of personnel of the Bureau of Health in the event of war. Since the professional personnel of the Bureau must be considered essential to the nation's needs in war on a par with the military, its entire group of professional personnel should be offered military status on the outbreak of war and should be available for obligatory service wherever the national interest demands. In the interest of flexibility the pattern of the military in maintaining a reserve corps should be followed by the National Bureau of Health. This reserve group, which would be of particular

importance in time of war or other national emergency, should be carefully selected with regard to professional representation and should receive periodically training in subjects related to anticipated assignments.

The new career service should include physicians, dentists, nurses, sanitary engineers and all other scientific personnel who are requisite for a general health program, such as non-medical scientists (in both the natural and the social sciences) working in the health field, pharmacists, dieticians, physical therapists, etc.

B. Greater Use of Ancillary Technical Personnel

The training of physicians has become increasingly complex and prolonged with the progress of medical science. But at the same time physicians have become unnecessary for many minor tasks. The same principle applies to graduate nurses. The armed forces in the recent war showed that there are many time-consuming tasks, customarily done by doctors or nurses, which can be performed satisfactorily by persons with far less technical training. Under the pressure of war, extensive emergency steps were taken to train and use such ancillary personnel to save scarce professional time. Since the war we have tended to relapse to the old groove.

Practical leadership is needed in this field, which is beset with obstacles in the form of state laws and the natural conservatism of professions with high standards. Since the Federal government can operate its own medical services without undue restrictions from state laws, and since the need to save professional personnel is so acute, the proposed National Bureau of Health and the armed forces medical service should provide an effective leadership and demonstration in this field.

XII. AID TO MEDICAL EDUCATION

The short supply of medical personnel has been cited throughout this report as a most urgent and vital reason for organizational change. It is necessary therefore to consider the source of this supply—the medical schools and teaching hospitals. Although our consideration is limited to the education of physicians, we are fully cognizant of the fact that the spotlight is being directed only to one of many areas of higher education, and only to one of many areas that produce personnel vital to the maintenance of the health of the nation. Because our primary task is to recommend an organizational structure that can cope with such problems, the education of the physician has been selected as the central one in the health area; also, the situation disclosed is one that may well require emergency measures.

The Federal government depends for its large supply of doctors during peace, as well as its staggering demands during war, upon the output of some 70 medical schools, 43 of which are supported by private funds (endowment, gifts, fees), mostly as integral parts of universities, and the remainder are supported by states and municipalities. Two studies made at the committee's request, quite independently of each other, confirm the distressed financial condition of a large number of these schools, definitely preventing their expansion and even threatening their very existence. That this situation is a critical one for Federal medicine is self evident, for shortage of medical manpower is its most serious problem.

As medicine has become more complex, standards of medical education have become more exacting and far more expensive for the schools to meet. Tuition formerly covered 70 percent of the expense of operating the schools. It now pays only about 25 percent, although tuition has been increased to the maximum amount tolerable and probably beyond the amount desirable. Inflation has of course added to the schools' financial difficulties.

The hope for large gifts for medical education from philanthropic foundations and wealthy citizens (with a very few notable exceptions), or for substantial support from commercial enterprises or public subscriptions, is judged to be remote. Federal support will be required, in spite of the potential dangers inherent in government subsidization. Resistance of the schools and of the profession to the acceptance of Federal aid can be resolved, provided assistance is offered on a basis which would not entail interference with professional educational policies but which would still provide to the taxpayer full justification for the aid and the purpose for which it is spent.

Some Federal funds are now directed to schools in the form of grants-in-aid and contracts for research and for some other specialized purposes, but these are of limited value in strengthening them and may actually add to the financial burden of these institutions as explained in the report of the Subcommittee on Research (Appendix J). A different kind of aid is needed.

The magnitude of the need has been estimated variously. The American Medical Association, although not favoring Federal aid, estimated that nearly $700,000,000 is needed at once to supplement the endowment of the private schools. In March, 1947, a representative of nineteen universities having medical schools, estimated that the private medical schools needed additional budgets of $30,000,000 per year. A more recent estimate is $16,000,000 per year more than is now available and about $200,000,000 for long range development of facilities.

These needs are not new. Many schools, which have never possessed adequate funds, have deficiencies in plant and personnel which urgently require correction. Practically all schools need additional physical facilities, especially laboratories, for replacement of old and outworn facilities. Confronted with the urgent problem of maintaining present standards, the schools have been unable to undertake new developments important to their educational programs.

Facts are lacking on which to base an intelligent program of comprehensive aid. There is no uniform system of accounting by the schools. Some are financially integrated with their universities, with affiliated hospitals, or with other schools (nursing, dental) or teaching units. Under such conditions we could not recommend Federal aid without a study which would develop enough facts to assure that the assistance would go to the areas of greatest need and that it would be utilized effectively for the desired purposes. A further reason for disapproving aid on a blind basis is that the best and probably the only way to get the facts is to make the receipt of aid conditional upon securing them.

One question which a study should answer is whether medical schools receiving aid might utilize their facilities throughout the year on an eleven-month basis instead of an eight-month basis. Some schools do this now; others do not. Many medical educators have expressed the opinion that the accelerated program of the war years resulted in deterioration in quality of education. However, this experience cannot be held conclusive, because at the time perhaps half of the faculties of the schools were absent in military service, a fact which alone might explain such results. When at one and the same time our medical schools are in such financial distress that the supply of doctors is threatened and our Federal medical services are in distress because they cannot obtain doctors, it is fair to inquire into any and all measures that may correct the situation. Although facts are not at hand to provide a basis for specific recommendations, they can be obtained before any policy of continued large grants is established.

We have tentatively considered several plans for the provision of Federal aid, and favor linking assistance (1) with an undertaking by the schools to increase enrollment up to the maximum point consistent with maintenance of high standards of education and (2) with a system of fellowships under which men of exceptional ability may be given an opportunity for medical education.

Fellowships are particularly needed to stimulate the training of research personnel, public health officers, and psychiatrists, to meet those shortages which are perhaps the most serious of all in their

implications for the future. For men willing to remain in research, continuing post-graduate aid should be provided, in order to keep them in what is potentially one of the most valuable of all medical activities but in which financial rewards are so meager that the basic financial security enjoyed by the skilled laborer is lacking.

For fellowships to be attractive to the holders and also of real help to the medical schools, the amounts provided would have to be much greater than the tuition plus the stipend paid to the student for his other expenses, because each additional student represents a further deficit to the school. Acceptance of such fellows as additional students would be a partial compensation for Federal aid.

Funds for capital improvements are also required. These can be furnished, like the aid to local hospitals, on a percentage basis, leaving initiative and responsibility in the schools to match the Federal aid. Since some school deficits stem from support of their teaching hospitals, the aid above proposed for such hospitals will diminish the aid to the schools.

Because the needs are acute, there is considerable pressure for interim aid in advance of a full-scale study and analysis of the facts. Certainly provision must be made to maintain the output of doctors from the educational system as it now exists. Since Federal assistance will be necessary for a long period, an intensive long-range study should grow out of an initial emergency survey.

Accordingly, we recommend:

First, that an initial survey of the acute emergency needs be made by the Public Health Service, with the aid of advisory groups representing the public, the medical schools and those philanthropic foundations which have given so generously to medical education. Where financial problems of an emergency nature are found which threaten the survival of medical schools or the maintenance of high standards of medical education, emergency financial aid should be supplied promptly by the Federal government if it is clear that the schools and their universities themselves are making maximum efforts.

Second, that a long range study of the economics of medical education be made to determine ways and means of insuring the maintenance of current output at present standards and of expanding output and elevating standards. This study, should define the extent to which present facilities can be better utilized and need to be expanded.

Third, a plan of fellowships for brilliant men, particularly those who evidence an especial interest in the fields in which there is the greatest shortage including Federal medical service.

These recommendations are predicated on the principle of not diminishing the essential independence of the schools in professional educational policies, or their self support to the full extent possible, or the private initiative now supporting them.

A sufficient principle on which to justify such Federal aid is that the government is the largest single customer for medical personnel even in peace, and by far the greatest customer of all in war.

XIII. MEDICAL SUPPLY

The purchase of purely medical items, which we may describe loosely as those used to treat patients, is a technical function requiring extensive professional knowledge and continuous adaptation to the changing techniques of the medical profession. For this reason, it is in the armed forces separated from other procurement, and such supplies are now bought for all three services by a joint medical procurement office.

Experience during the war, when the biggest medical supply enterprise of all time was conducted—over a billion dollars worth of such supply and equipment being bought by the Army alone—demonstrated irrefutably that such an operation should be under medical control to select items, to regulate specifications, quantities, packing and standards closely in accordance with the using doctors' needs, and to develop, procure and distribute promptly new items as the constant progress of science and as medical experience modifies existing concepts.

This principle is violated in the Veterans Administration, in which the supply service is on an equal basis with, and wholly independent of the Department of Medicine and Surgery. After the war, V.A. was destined for a long time to use large quantities of armed forces surpluses. Had a unified medical supply service been developed, the V.A. could have been effectively serviced with no mass shifting of these stocks. But the natural desire of each agency to control and operate its own enterprise, and the further fact that in the V.A. the supply service was an organization separate from its medical department, resulted in the movement of great stocks of supplies at large expense, the rewarehousing of them in V.A. depots and in a continuing duplicating service.

Today, although there is no need in a properly conducted unified supply system for more than a three months' depot stock level, except for war surplus and war reserve stocks, the V.A. authorizes a six months level. Actually V.A. has a two year level, explained largely by

war surplus stocks. Recently the V.A. supply organization proposed to increase its stocks by another $33,000,000, but this unnecessary expense was averted by the Bureau of the Budget. The V.A. medical supply operation is neither an economical one, nor satisfactory to the doctors being served. In spite of its enormous stocks a large amount of local procurement (58 percent of the total) is necessary at high cost. A substantial part of the supplies could be furnished by purchases under open-end general contracts with direct delivery from the sellers, greatly lessening the depot function. We understand that steps in this direction are now in progress.

Even more serious is the fact that there is no complete common Federal medical supply catalog, and, therefore, inadequate standardization except in the armed forces.

In the armed forces, the procurement system has been consolidated for the past three years and operates satisfactorily. This procurement office with some expansion could readily buy all the medical supplies required for the Federal government as a whole.

However, the armed forces have never been able to get together on warehousing or stock control, and the Army and Navy operate wholly separate depot systems with duplication and unnecessary expense. The Army authorizes a three months stock level, the Navy a six months level, in depots. In the Army, which includes service to the Air Force, warehousing could be contracted by 25 percent at least. Large amounts of stocks are also carried at the stations (hospitals). We have reason to believe that these are in many stations far in excess of needs. A sixty to ninety day level is all that is necessary.

Total government stocks of medical supplies are $177,000,000 against an annual issue of $44,000,000, or a total of about four years stock expressed dollar-wise. These deteriorate and are costly to keep. Of course they represent in substantial part war surplus which was properly retained, but the very size of the total stocks makes single control of them, of their warehousing and utilization even more important.

The loss due to the present independent systems can be illustrated by the existence of 17 depots carrying major amounts of supplies; (aside from 12 other depots of the Federal Bureau of Supply which include some medical supplies) although an over-all unified Federal medical supply system properly conducted would require only four to seven depots, roughly one-third of those now used.

Progressive reduction in inventory with savings in very large amount would follow this change automatically, although it would of course take time to realize the full benefit.

Such consolidation of stocks could still provide for sufficient dispersion to protect against danger of loss due to bombing, while on the other hand making the stocks much more readily available should a crisis arise, since they would all be a part of one system and would be standardized.

Before making this recommendation, we checked informally with the Commission's task force undertaking the study of Federal procurement, and ascertained that our plan for separate procurement of purely technical medical items would not be inconsistent with its recommendations.

We feel justified in stating categorically that there is no need for more than a single medical supply system, including single systems of stock control and warehouses for the entire Federal government, and that better service can be given with significant savings.

In such a plan, it must be remembered that the armed forces require for military preparedness a complete supply system, with stocks of all items in depots, and with facilities, plans and experience for the rapid assembly in an emergency, of hospitals and other military medical units complete (except for buildings) for possible overseas use or catastrophes here. This does not mean that the armed forces could not for current consumption buy many items for direct delivery to the using station, wherever this could be done more economically.

In the civilian medical agencies which would become part of the new Bureau of Health, there is no corresponding need for a complete supply system in the same sense. For their purposes, the criterion should be, on an item by item basis, whether considering all indirect as well as direct costs it is cheaper to buy locally, or wherever possible under open-end general contracts, for direct delivery to the using station, or to take delivery in government depots in larger quantities, and therefore at lower cost to the manufacturer and fill station requisitions from the depots.

If the armed forces were merged, or if responsibility for medical supply were assigned exclusively to one of the three services, such function could also be performed effectively for the Federal government as a whole. This would, of course, include supply only to the depot level; that is, the stations (hospitals) of each service and of the Bureau of Health would not be included in the central system; also overseas supply would still be the function of the respective armed forces concerned.

The above plan would be consistent with the report on Civil Defense for National Security to the Secretary of Defense, which recommends that the Army conduct procurement and warehousing of the large quantities of medical supplies requisite for civil defense.

We recommend against having the armed forces assume responsibility for medical supply both for themselves and civilian Federal medicine if the operation would have to be conducted as a joint function of the three services, resting necessarily in considerable degree upon their mutual concurrence. A single responsibility and authority is needed. But, of course, such proposed delegation to one service would not prevent the inclusion by detail of personnel from the other services, to any reasonable extent that the latter desired to have their officers trained in medical supply work.

A great advantage to the armed forces in the method here proposed would be that their personnel would have training and experience in handling a large medical supply system instead of the relatively small peacetime armed forces operation. The civilian Federal medical agencies would be the largest consumer except in war, and the operation would, therefore, be very much bigger than one conducted for the armed forces alone. Inadequate experience in large scale medical supply operations preceding the recent war caused many months of anxiety and protracted deficiencies. It should be avoided again.

Unless there is either a merger of the medical services of the armed forces or a delegation of exclusive responsibility to one of them, we favor the alternative of placing the unified supply service in the National Bureau of Health, and of letting it take care of the armed forces peacetime needs in addition to its own. In such event the armed forces would operate only the depots containing the war reserve. But they would detail personnel to the National Bureau of Health for training and experience in medical supply to the extent that the armed forces find reasonable need to do so. The invaluable knowledge of the senior personnel of the medical supply services of the armed forces should be made available by such detail.

In making this alternative recommendation, we are fully aware of the strong feeling of the armed forces as to controlling all of their logistics. Under the first recommendation made, they would have the option to do this. But if this option is not exercised, certainly the advantages of unified supply, in economy and in better availability of stocks for a war emergency both for civilian defense and the armed forces themselves, outweigh other considerations. *Unified supply under a single responsible head is a must if the objectives of P. L. 162 are to be achieved.*

One of the greatest advantages of such unified supply would be government-wide standardization of items. Through this, plus single control, stocks could be mobilized rapidly either for civilian defense or the armed forces, should emergency arise. If there were no other advantage than this, the unified service would be justified.

Finally, as one important feature of war preparation, the armed forces and the planners for civilian defense should standardize hospital assemblies. It has been proven that items can be standardized. This can and should be done also as to assemblies. It will not be possible to predict which hospital assemblies will be needed for the Army, the Navy, the Air Force or civilian defense. They should, like their component parts, be standard and interchangeable. We understand progress toward this end is being made. It should be accelerated.

For such unified procurement enterprise to operate, there would of course have to be one law regulating the methods of procurement authorized which would be applicable to the entire function. For example, P. L. 413 of the 80th Congress allows negotiated purchasing, rather than formal advertising and bid, under certain conditions in procurement for the armed forces. The same provisions would have to be extended to include the part of the proposed procurement conducted for the benefit of the civilian agencies.

For more detailed discussion of medical supply with additional factual data supporting the present conclusions, we refer to the report of our task force (Appendix K).

XIV. PROVISION FOR CONTINUING STUDY AND TOP-LEVEL SUPERVISION OF FEDERAL MEDICAL SERVICES

At best, there must because of special military needs continue to be at least two major separate Federal medical services. Further, military medicine itself will probably be divided among the three armed services. While coordination among the armed services is provided for in the above recommendation for the Deputy and the advisory committee to the Secretary of Defense, the plans which we have so far proposed do not bridge the gap between the military and the non-military Federal medical organizations. Therefore, a top-level mechanism for over-all study, supervision and coordination is requisite. The studies made by our committee should be the beginning, not the end, of such surveys and appraisals. In the time available, our work could provide only an outline of organization, a few signposts, evidence of the real need for such studies, and some indication of what might be saved by them. Such a continuing study properly conducted, and accompanied by top-level supervision, could pay for itself hundreds of times over, and help to assure the most effective use of our limited professional resources.

The function includes positive coordination and supervision as well as fiscal review. The first should afford a continuing and dynamic ap-

praisal of all the inter-relationships within Federal medicine, and between Federal medicine and the civilian medical economy in all fields. The second, fiscal review, by its very nature is essentially a negative operation.

Under present Federal organization, the Bureau of the Budget is the logical office to discharge both types of responsibility. The powers of the Director of the Budget are far broader than the responsibility for fiscal review which the title of his office connotes. However, the Bureau of the Budget has customarily centered its attention on essentially fiscal matters. This might tend to overshadow the positive dynamic studies and coordinating activities which are our principal concern. The Bureau's Hospital Division has assembled valuable data and has shown a grasp of the fiscal and organizational problems of Federal medicine; it is well equipped for the fiscal review function. We are not concerned that there will be an inadequacy in this area; we are concerned as to the establishment and exercise of the other function.

Since the Chairman of the Commission is himself making recommendations concerning the organization of the Office of the President, it may be that some new organizational provision will be made for the kind of positive activity we recommend so strongly. If not, the broad powers of the Director of the Budget should be employed for it.

To assist in the guidance of this important work, we recommend a medical advisory committee. Such advisors should be completely separate from, and independent of, the operating agencies.

XV. THE NEED FOR INCREASED EMPHASIS ON THE CONTROL OF DISEASE

Federal medicine shares with all medicine and other healing arts an intense preoccupation with the diagnosis and treatment of disease. In fact, in the mind of the layman this constitutes medicine. As methods of greater precision and certainty have developed, both diagnostic studies and curative treatment have required more and more hospital beds. The fact must not be forgotten that the hospital as we know it today is a product of this century. Society has had less than fifty years experience with this institution in its present form.

We have outlined the cost and the problems that provision of medical service—in varying degrees—for one-sixth of the population has already imposed on the Federal government. This has been measured in the convenient unit of a hospital bed, but this unit fails to measure the constant need for replacement of the rapidly outmoded equipment and apparatus of the modern hospital, the cost of expensive

drugs and biologicals, and the increasing needs for manpower. We have expressed our concern about, and based recommendations on, the fact that the existing plant and commitments have already outstripped the supply of medical personnel.

Attention has been called to the expectation that in the hospital care of veterans alone, unless earlier rates of hospitalization for diseases are decreased, there will be under present policies between a twofold and a threefold increase required as World War II veterans grow older, with a staggering annual cost for many years. Even if no veteran with nonservice-connected disability should be hospitalized except for chronic diseases, 250,000 beds will be needed by 1975 for veterans, and *more than three-fourths* of these would be for mental patients, according to an actuarial study just made for our committee in the Metropolitan Life Insurance Company (Appendix L).

We have noted from responsible nongovernmental sources, disturbing reports of financial deficits in the voluntary hospital system, of inadequate philanthropy and of only partially filled community chests.

Is there no end, society may well ask, to this demand for more and more beds? Are the doctors, through their discovery of new and better ways of treating disease, quite unintentionally creating a burden that is already irksome, and threatens to prove intolerable? If we think solely in terms of the provision of medical care as it exists today, we agree that the outlook is alarming. But there are certain courses that, if followed, may provide a way out.

The first of these, except in very limited degree, is beyond any direct influence of the Government. The pattern would need to be established first by nongovernmental medicine through bringing about a closer integration of the hospital and its community, with the objective of diminishing the need for hospitalization through a relative increase of ambulatory care. Before the Government can even approach this problem, we have noted that a clear definition of its policies in relation to certain beneficiaries would need to be established. The Government is now committed to quite the reverse policy, at least in the care of nonservice-connected disabilities of veterans, who constitute the great bulk of its beneficiary population. In their case, the Government in effect is using the inconvenience of hospital admission as a means to check the flood demand of ambulatory care that would result if this were to be provided. Under present circumstances, we cannot question the wisdom of such a course, except in tuberculosis, mental illness and syphilis, not only because professional manpower for such an undertaking is nonexistent, but because the cost would be prohibitive. The pharmacy costs alone for adequate ambulatory treatment would be fantastic.

The second course, and the one that should be followed vigorously, is one in which the Federal government in recent years has often times exerted leadership, and with courage and imagination forged ahead of non-Federal medicine. This is research and development in public health and preventive medicine.

It is necessary to define preventive medicine to achieve clarity of thinking in regard to it. The prevention of disease may be achieved by specific measures that protect the individual from contracting a disease. If communicable disease is involved, such measures generally reduce the incidence of the disease in the community and prevent explosions in epidemic form. This is a limited definition of preventive medicine, best exemplified by vaccination for smallpox. Preventive medicine also includes the prevention of death and disability through early recognition and treatment of disease that is already established. Aside from the benefits to the individual, the effect of this form of preventive medicine in communicable disease may also extend as protection to other individuals in the community. For example, in tuberculosis the best preventive measures are incident to an early diagnosis and treatment that detects and isolates the case and so removes the source of contagion from the community. It can thus be seen that preventive medicine merges on the one hand with public health and on the other hand with remedial medicine, depending on the point of view.

The combined action of these two phases of preventive medicine, as we have defined it, constitutes what is commonly hailed as the progress of scientific medicine. It is quite true that at the present time this progress can be accused of having added complexity, and also, from the economic standpoint, its dollar balance on the ledger may still be in red ink. But scientific medicine has scarcely started toward its goal. It is not inventing new diseases—it is carefully sorting out the same old diseases and one by one bringing them under control.

We are likely to forget the significance of those many serious illnesses that have already been checked or eliminated. It is obviously impossible to give more than the roughest approximate estimates in money savings. Perhaps these should not be attempted at all, because no one can assign a dollar value to the health of an individual and the productivity of a great nation. A few illustrations will suffice:

Diphtheria: Some 50,000 more persons would have died of this disease in 1947 if the 1900 mortality rates had prevailed. The 1947 cost to the nation would thus have amounted to $30,000,000. The actual expense was $600,000.

Typhoid and paratyphoid: Over 40,000 lives were saved in 1947 as a result of the decline in typhoid mortality since the turn of the century. The cost of the disease was reduced from $45,000,000 to $800,000.

Diarrhea and enteritis: 150,000 more deaths from diarrhea and enteritis would have occurred in 1947 if mortality from this cause had remained at its 1900 level. Savings are estimated to be greater than either in diphtheria or typhoid fever.

Tuberculosis: The annual mortality rate among males aged 25 to 34 has been reduced in the present century from 275 per thousand to only 39. Without such control, 25,000 additional men of those ages would have died in 1946.

At the present time we are drafting men from 19 to 25 and, because of the progressive reduction in deaths from tuberculosis, 150,000 men subject to the draft are now alive, available for call to military service, who would have been dead had the death rate from this disease continued as it was at the time they were born.

In the armed forces, X-ray and other screening at induction kept 200,000 cases of tuberculosis out of service. The incidence of this disease among active duty personnel and among veterans since the war was reduced to about one-tenth of that during and following World War I. Savings in dollar cost to the Federal government for chronic care are of incalculable magnitude and there is respectable expert opinion that maximum effort could bring tuberculosis under control within measurable time.

Malaria: The remarkable effectiveness of the control over malaria is brought out by the experience of the armed forces in the Pacific. During 1943 in the Southwest Pacific, hospital admissions from malaria rose to 250 per thousand. Peak rates were even higher. Several additional divisions were made available for combat by the application of antimalarial measures which reduced these rates to less than 50 per thousand.

It will be noted that all of these illustrations fall into the category of infectious diseases and that control measures for them developed on the basis of research discoveries both in natural science and medical science.

The extraordinary advance made in the control of these and other infectious diseases has prevented death and improved the health chiefly of persons under 45 years of age. This advance can be reckoned as one of the several factors that account for the increase in life expectancy

illustrated by the fact that white males at birth now have a life expectancy of 67 years contrasted with that of 50 years as of the beginning of the century.

Compared with the advance in the control of infectious diseases, however, relatively little has been accomplished for the chronic diseases, the incidence of which begins to rise sharply after 40 years of age. The magnitude of this problem can be estimated from the calculation that, of the 2,000,000 man years lost annually by the nation's labor force, more than two-thirds is lost on account of chronic diseases. This discloses a problem that is not only large but increasing, because of the greater span of life just noted. At present, there are in the population 39,000,000 persons aged 45 or over. In 1980, it has been estimated that there will be 59,000,000.

These statements have peculiar significance when applied to the population of veteran beneficiaries. We have presented the judgment that chronic disease disability in the veteran leads to almost automatic identification with inability to pay, and on justifiable grounds. Just now, we are in the peak load of chronic care for veterans of wars prior to World War II, whose average age is close to 60. The average age of World War II veterans is but 30. The two groups numerically stand in the ratio of 4 million to 14.5 million. It is easy to see that when the latter group passes 45, there will begin an unprecedented demand for hospitalization by the Federal government.

A term used in relation to disease in recent years now requires definition—*control.* It embraces not only preventive medicine in the broad sense in which we have defined it, but research and education. Education includes not only doctors, but all persons working in the health area, as well as the chain of research workers that extends back to the laboratories of natural science. Control, then, is measured by high grade medical service oriented toward preventive measures, research and education.

Cognizant of the task the government is facing in chronic disease, it is important to inquire what it is doing toward control. This can be estimated by considering the amount expended for medical research, aside from education, which is the control measure indicated to anticipate the increasing task ahead.

In the year 1948, over 85 percent of the Federal medical expenditures in the United States was for medical service—that is the care of established disease among the Government's particular beneficiaries. Only 8.9 percent was spent for all projects related to public health and preventive medicine for the population as a whole, and but 3.9 percent for research.

It is true that the total expenditures for research have been increased very considerably in the past decade, but comparison of relative amounts convinces us that the necessity for even greater expenditure has not been faced. Increases in expenditure for medical care are outstripping relatively those for control. The reverse should be the case.

Our understanding of chronic disease is still in its infancy. Strategists in medical science have already mapped it as the next great theatre of operations. Although there is no guarantee that because one disease has been conquered another will fall, there is every reason for confidence and optimism in the great potential of our national research capacity. The broad three-pointed program of control yields appreciable results even while the spearhead of research is seeking a breakthrough. This is the present situation in cancer. The full application of existing knowledge can greatly diminish the human suffering and economic wastage of this disease.

We stand confident then in the recommendation of a courageous approach to the control of chronic disease, rather than a passive acceptance of the immeasurable cost that lies ahead. Funds invested in research and education at this time will not only return dividends in dollar savings in the future, but a still greater reward in health and productivity in the nation.

XVI. CONCLUSION

Congress has asked you to recommend changes necessary to promote economy, efficiency and improved service. You have asked us to make such recommendations in regard to Federal medical services. We have done so. In this process, we have used figures of excesses which exist and economies which might be effected. These are not offered as precise appraisals, but merely as illustrations that large areas of savings can be opened by sound organization. We have attempted to outline a method which we hope will correct the extravagance resulting from the present series of unrelated projects, and weld these together into an integrated, orderly whole. With such an organization, staffed by outstanding personnel, it should be possible to utilize our unequaled medical resources to the maximum, and by intelligent planning take steps which will make us a healthier and stronger nation.

APPENDIX A

Organization of the Work of the Committee on Federal Medical Services

Following the example of the Commission, we delegated major areas of work to task forces, which were assisted by the full-time staff of the committee and by such special assistants and advisors as the heads of the task forces desired.

Dr. Edward D. Churchill, as vice chairman, and Dr. Ray Lyman Wilbur assisted the chairman in giving general guidance to the committee's task.

In medical care the most expensive and damaging policy is to continue to center expenditure on hospitalization and the care of diseases while neglecting research, preventive medicine and public health. We, therefore, gave a high priority of attention to these.

Medical Research:

We set up a task force in this field and to head it arranged for the addition of Dr. A. N. Richards to our committee. He had served as Chairman of the Committee on Medical Research of the wartime Office of Scientific Research and Development. He was assisted by Dr. O. H. P. Pepper, and had Dr. A. R. Dochez as an advisor.

Public Health:

We secured the addition to the committee of Dr. Hugh R. Leavell, Professor of Public Health Practice at Harvard, to make the study in this field. We endeavored to coordinate this work with that of the Brookings Institution in its study of Welfare.

Neuropsychiatry and Tuberculosis:

Approaching our problem from an entirely different angle, we instituted special studies in the two great chronic diseases—tuberculosis and psychiatric illnesses—which together account for 60% of all Federal hospitalization. These, because of their chronicity, make almost all patients medically indigent, and are the greatest expense to the Federal government. In the psychiatric field, Dr. William C. Menninger headed our study. For tuberculosis we consulted Dr. Esmond R. Long, perhaps the foremost authority in the country, and with his aid and advice obtained Dr. Robert Plunkett from the New York State Department of Health. Dr. Plunkett directed the study; Dr. Long served as consultant. The conclusions represented their joint opinion.

Hospitalization:

Studies of hospital and medical services were divided in several ways. As to the armed forces, they were under Dr. Paul R. Hawley, formerly the Army's Chief Surgeon in the European Theater of Operations, and later Chief Medical Director of the Veterans Administration. Dr. Michael E. DeBakey, Dr. Hugh J. Morgan and Dr. Menninger were also members of this task force. Through liaison with Dr. Howard A. Rusk and Dr. Richard L. Meiling, our work was integrated with that of your Committee on National Security Organization.

Under the parent task force on Hospitalization, of which the chairman was Dr. Allen O. Whipple, surveys were made of all Federal hospitals in several representative areas; a special study was made of residency training; and a study was made of the need for possible aid to medical education. In addition to the members of Dr. Hawley's task force, the other members of the Subcommittee on Hospitalization were Drs. Frank R. Bradley and R. C. Buerki, Messrs. Henry P. Isham and Charles F. Rowley. Drs. Basil MacLean and Maxwell E. Lapham served as advisors in special parts of the work.

Medical Manpower:

We created a task force on medical manpower, and for this purpose arranged to add to the committee Dr. Edward D. Churchill, who had previously studied this problem as Chairman of Secretary of War Patterson's Medical Advisory Committee. Mr. Goldthwaite H. Dorr also served on this task force.

Medical Supply:

A special study was made of medical supply by persons experienced in military medical supply during the war. In this the Chairman of our committee personally participated. Mr. Herman Hangen and Mr. C. W. Harris served as advisors in this work.

Organization:

Since the ultimate objective of all our efforts was to provide a sound organization for medical services, a special Subcommittee on Organization, under the chairmanship of Mr. Dorr, was created for continuous consideration of this ultimate goal. Dr. DeBakey, Dr. Hawley, and Mr. Tracy S. Voorhees served as members of this subcommittee.

Both formally and more often informally, representatives of all of the major Federal agencies affected, the principal professional

groups concerned, and several of the veterans organizations were invited to present their views orally or in writing to the committee as a whole.

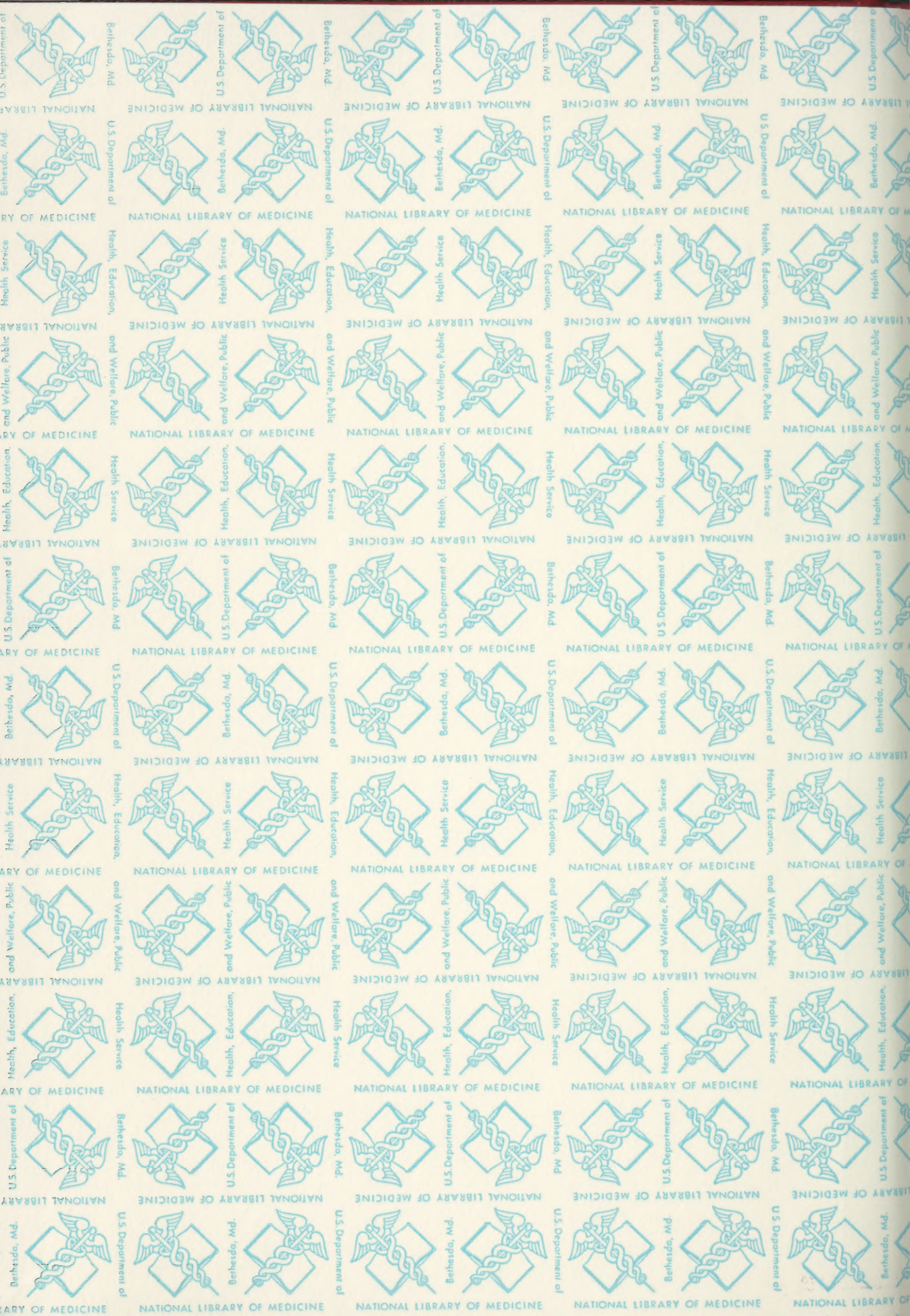
General Edward S. Greenbaum and Dr. Gilbert W. Beebe assisted in the preparation of the final report. Dr. Eli Ginzberg assisted the committee as an advisor in the earlier phases of its work.

Staff:

The committee's staff also conducted extensive fact-finding investigations. The staff consisted of Dr. Howard M. Kline as Executive Director, Messrs. Marshall Hornblower, Daniel I. Rosen, Edward A. Lew (as actuary), Leslie T. Roach, Thomas Dolgoff, Jack Colclough, Joseph C. Corie, W. V. Charters, William Schweitzer and Mrs. Amy W. Firfer.

Special staffs for the task forces included: Mr. William McPeak for Manpower; Dr. Jack R. Ewalt for Neuropsychiatry; Dr. Richard Nauen and Dr. Edward X. Mikol for Tuberculosis; Dr. Julius Comroe, Jr., for Research; Dr. James Troupin for Preventive Medicine; Dr. E. Richard Weinerman for Hospitalization; and Dr. H. F. Currie and Dr. B. C. Fenton for Medical Supply.

Miss E. Hildegarde Hillberg and Miss M. Louise Williams directed the secretarial staff of the committee.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